DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ken Janowski
Strategic Reimbursement Group, LLC
16408 E. Jacklin Dr.
Fountain Hills, AZ 85268

RE: ***Jurisdictional Decision***
Ukiah Valley Medical Center (Prov. No. 05-0301)
FYE 12/31/2012
Case No. 16-2559

Dear Mr. Janowski:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents filed in the above captioned case. The Medicare Contractor has filed a Jurisdictional Challenge over one of the issues, and the decision of the Board is set forth below.

Background

On September 27, 2016, the Board received Ukiah Valley Medical Center's ("Provider's") Individual Appeal Request. The Provider is appealing from its Notice of Program Reimbursement ("NPR") dated May 3, 2016.[1] The total amount in controversy listed on the appeal request is $270,995. The appeal request contained just one issue when filed:

1. Inclusion of California § 1115 waiver days (Medicaid Ratio)[2]

On November 1, 2016, the Board received a request to add the following issue:[3]

2. Low-Volume Hospital Adjustment ("VDA issue")

The estimated amount in controversy for this issue is $341,080.

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[1] A hearing request must be received no later than 180 days after receipt of the relevant final determination. 42 U.S.C. § 1395oo(a)(3); 42 C.F.R. § 405.1835(a)(3). The Individual Appeal Request in this case was received 147 days after the NPR was issued.

[2] Two other issues appear in the Provider's Final Position Paper: #3 DSH Medicaid Eligible Days, and #4 Dual Eligible Part C Days (Medicaid Fraction). Provider's Final Position Paper, 1 (Oct. 12, 2021) ("Provider's FPP"). The Medicare Contractor alleged these issues were improperly added to the appeal. MAC Final Position Paper, 2-3 (Nov. 10, 2021) ("MAC'S FPP"). Issue #4 was transferred to the CIRP group appeal under Case No. 17-0261GC on November 15, 2016, and Issue #3 was withdrawn by the Provider on December 27, 2021. As a result, the Board need not address its jurisdiction over Issue #3 as that was withdrawn. The Board will address its jurisdiction over Ukiah's alleged Part C days issue in Case No. 17-0261GC.

[3] Issues may be added to a hearing request no later than 240 days after receipt of the relevant final determination. 42 C.F.R. § 405.1835(e)(3); Board Rule 11.1 (2015). This issue was added 182 days after the NPR was issued.

The Provider describes the VDA issue as follows:

> Whether the Intermediary's adjustment numbers 21 and 22, the denial of reimbursement for the inpatient hospital payment adjustments for low-volume hospitals, are in accordance with C.F.R. Regulation 412.101. It is the Provider's opinion that the hospital qualifies for the low volume adjustment to the DRG payment as they fulfill the requirements of being classified as a rural provider, have less than 1,600 Medicare discharges and the nearest prospective payment provider is more than 15 road miles.[4]

With regard to the dissatisfaction requirement for the VDA Issue,[5] the Provider cites Audit Adjustment Nos. 21 and 22 to its cost report. Both audit adjustments concern the following:

> WPR: F-P1
> E, Part A, Title XVIII, Hospital Column 1.00 Inpatient Part A Ref: 42 CFR 412.110/413.20, CMS PUB 15-1 Sec. 2408.4

On April 27, 2018, the Medicare Contractor filed a Jurisdictional Challenge over the VDA issue. As that Challenge, the Medicare Contractor describes the Audit Adjustment Nos 21 and 22 as follows:

> Adjust #21 was to adjust Worksheet E Part A column 1 settlement data to the updated PS&R while adjustment #22 was to adjust Worksheet E Part A Column 1,01 settlement data to the updated PS&R.[6]

The Provider did ***not*** timely file a response to the jurisdictional challenge in compliance with Board Rule 44.4.3.

Positions of the Parties

Medicare Contractor's Jurisdictional Challenge:

The Medicare Contractor claims that neither of the adjustments cited by the Provider for this issue are related to the VDA issue and that the filed cost report did not include the reimbursement impact of this issue as a protested amount.[7] It also argues that, since there was no audit adjustment, the Provider is dissatisfied with its own reporting of the VDA issue and not the Medicare Contractor's determination of the issue.[8]

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[4] Request to Add Issue, Tab 1 (Nov. 1, 2016).
[5] 42 U.S.C. § 1395oo(a)(1)(A); 42 C.F.R. § 405.1835(a)(1); Board Rule 7.1.A. (2015).
[6] MAC's Jurisdictional Challenge, 2 (Apr. 27, 2018).
[7] *Id.* at 2-3.
[8] *Id.* at 4.

The Medicare Contractor acknowledges that the Board may have jurisdiction over some issues that were not adjusted or self-disallowed (protested) pursuant to the holdings in *Bethesda Hospital Association v. Bowen*[9] and *Banner Heart Hospital v. Burwell*.[10] It notes that such issues are limited to those which would be futile for the Provider to present to the Medicare Contractor because the latter would have no authority to allow the cost or claim, such as a challenge to a regulation or policy. The Medicare Contractor claims, however. That requesting to be classified as eligible for a Low Volume Payment "is something that is squarely within the MAC's purview to address."[11] The Medicare Contractor argues that neither *Bethesda* and *Banner Heart* allow the Board to assert jurisdiction over costs or claims which were overlooked by the provider due to ignorance, oversight, negligence or otherwise.[12]

Provider's Position:

The Provider did ***not*** timely file a separate response to the April 27, 2018 Jurisdictional Challenge. In this regard, Board Rule 44.4.3 states:

> Providers ***must*** *file a response within 30 days* of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.[13]

On October 12, 2021, the Provider filed its Final Position Paper. While the Position Paper does not directly address the Jurisdictional Challenge (which would be untimely), it explain why it filed the add-issue request for this issue, stating:

> The Provider elected to add this issue to the appeaì as the provisions to add the low volume adjustrnent did not commence until federal fiscal year 201 1 which was the first year that the Provider qualified for the low volume add-on, and it was the Provider's opinion that the Intermediary would retroactively inciude the low volume adjustment once it was verified that the provider had less than 1,600 Medicare discharges during the selected CMS base period.[14]

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[9] 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.).
[10] 201 F. Supp. 3d 131 (D.D.C. 2016).
[11] MAC's Jurisdictional Challenge at 6.
[12] *Id.* at 7.
[13] (Emphasis added.)
[14] Provider's Final Position Paper, 15-16 (Oct. 12, 2021) ("Provider's FPP").

Medicare Contractor's Position:

The Medicare Contractor filed its Final Position Paper on November 10, 2021. It reiterates that neither cited audit adjustment relates to the VDA issue and that the Provider did not include the impact of the understated low volume amount in its protested items.[15] It also notes that, on its filed cost report, the Provider noted it was ***not*** eligible for a low volume adjustment on Worksheet S-2, Part I, Line 39.[16]

On the merits of the position, the Medicare Contractor argues that, for FY 2012, the Provider did not actually have fewer than 1,600 Medicare Discharges,[17] which is a requirement for the low volume add-on payment for FY 2012.[18]

Relevant Law

Neither of the audit adjustments cited by the Provider for the VDA issue actually relate to the issue. Thus, the Board must determine whether the Provider has met the dissatisfaction element for the Board to have jurisdiction over this issue under CMS Ruling 1727.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[19] 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.[20]

On August 21, 2008, new regulations governing the Board were effective.[21] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[22] In *Banner*, the provider filed its cost report in accordance with the applicable

[15] Medicare Administrative Contractor's Final Position Paper, 12-13 (Nov. 10, 2021).
[16] *Id.* at 13 (citing Exhibit C-14).
[17] *Id.* at 14, 21-22.
[18] *Id.* at 14-15 (citing Section 1886(d)(12) of the Act, as amended by §§ 3125(3)(B), 4(d) and 10314(1), (2), Pub. L. 111-148; 42 C.F.R. § 412.101).
[19] 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.).
[20] *Bethesda*, 108 S. Ct. at 1258-59.
[21] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[22] 201 F. Supp. 3d 131 (D.D.C. 2016).

outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for expedited judicial review 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.[23]

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 still elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

Decision of the Board

The first step of analysis under 1727-R involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. The instant appeal was filed on September 27, 2016 and is currently open, so it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal concerns a cost reporting period ending December 31, 2012, so the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other 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."[24] Low volume payment adjustments must be requested by a provider on their cost report. Low volume hospital adjustments appear on Lines 70.96-70.98 of Worksheet E, Part A.[25] Neither Audit Adjustment #21 or 22 contain reference to these lines.[26] In fact, Lines 70.96-70.98 all read "0" on the cost report submitted with the Provider's Initial Appeal Request.[27] Also, to request a low volume adjustment, Columns 1 and 2 on Worksheet S-2, Part I, Line 39,must both be marked "yes."[28] The applicable cost reporting instructions note that "[t]he response to these questions determines

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[23] *Id.* at 142.
[24] CMS 1727-R at unnumbered page 6, *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/CMS-1727-R.pdf.
[25] Provider Reimbursement Manual 15-2 ("PRM 15-2"), § 4030.1 (Form CMS-2552-10 instructions), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935 (copy at Exhibit C-12).
[26] The closest reference is to line 70.93, which relates to hospital value-based purchasing.
[27] Initial Appeal Request, Exhibit 10.
[28] PRM 15-2 at § 4004.1.

the completion of the low-volume calculation adjustment."[29] In the cost report submitted with the Provider's Initial Appeal Request,[30] both of these columns are marked "no."

Based on the foregoing, the Board finds that the Provider's VDA issue ***was not*** "subject to a regulation or other 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." The Provider could have requested a low volume adjustment on its as-filed cost report, but failed to do so. Instead, the Provider's final position paper states in hindsight that the Provider believed that the Medicare Contractor would retroactively include the adjustment once it was verified that Provider met the criteria.[31] Accordingly, the Board finds that this issue ***does not meet the second requirement or step of Ruling 1727***.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in 42 C.F.R. § 405.1835. Since the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an "allowable" item. In the instant appeal, the low volume payment add-on ***was*** within the payment authority of the Medicare Contractor. As such, Ruling 1727 mandates that, "if the provider's cost report did not claim reimbursement for the allowable item in the manner sought by the provider on appeal, and the provider has not demonstrated a good faith belief that the item was not allowable, see (73 FR 30196), then the provider has not met the dissatisfaction jurisdictional requirement in § 405.1811(a)(1) or § 405.1835(a)(1), as applicable."[32] In the instant case, the Provider has made no claim or argument that it believed the VDA issue was not allowable.[33] As such, the Board has determined it does not have jurisdiction over the issue.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, the low volume payment add-on ***was*** within the payment authority of the Medicare Contractor. Thus, step four is not applicable.

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[29] *Id.*
[30] Initial Appeal Request, Exhibit 10. *See also* Exhibit C-14.
[31] Provider's FPP at 15-16.
[32] CMS 1727-R at unnumbered pages 6-7.
[33] The Provider has not suggested it protested the low volume adjustment and the Medicare Contractor has confirmed that it was not protested. Indeed, it appears that it would not have been appropriate to protest since the Provider could (but failed) to claim a low-volume adjustment on its as-filed cost report.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. If a Provider self-disallows a specific item by filing the pertinent parts of its cost report under protest, but the Board determines that the Medicare Contractor actually had the authority or discretion to make payment for that specific item, then the Board must apply step three of 1727-R. As previously noted, the Provider did not self-disallow or protest the anything related to the low volume payment adjustment.[34]

Conclusion:

The Board hereby finds that they lack jurisdiction over the VDA payment. The cited audit adjustments, protested item support, and relevant cost report worksheets indicate that the Provider did not request a low volume payment adjustment, even though it could have. As a result, the Provider has not met the dissatisfaction requirement[35] for a hearing and the Board dismisses the Low Volume Payment Adjustment issue from the case. Since the Section 1115 Waiver Days issue is still pending, the case will remain open.

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

Board Members:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

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

[34] *See* Exhibit C-3.
[35] 42 U.S.C. § 1395oo(a)(1)(A); 42 C.F.R. § 405.1835(a)(1); Board Rule 7.1.A. (2015).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nina Marsden, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East, Ste. 1600
Los Angeles, CA 90067

RE: ***Jurisdictional Decision***
Clovis Community Medical Center (Prov. No. 05-0492)
FYE 8/31/2011
Case No. 15-1932

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents filed in the above captioned case. The Medicare Contractor has filed a Jurisdictional Challenge, and the decision of the Board is set forth below.

Background

On March 24, 2015, the Board received Provider's Individual Appeal Request appealing their October 15, 2014 Notice of Program Reimbursement ("NPR") for fiscal year ending August 31, 2011. The initial appeal contained the following five (5) issues:

1. DSH Medi-Cal % Medi-Cal Eligible Days
2. DSH Medi-Cal % Medi-Cal Eligible Days Status Code 3 Days
3. DSH Labor & Delivery Days
4. Bad Debts RAD Code 408
5. DSH SSI % Fraction to included Medicare Part A

In its initial appeal request, the Provider described Issue 3: DSH Labor & Delivery Days, as follows:

> Labor Room Days were erroneously included twice in the Total Days (1,005 Labor and Delivery days) for the Disproportionate Share calculation (DSH). The cost report Worksheet S-3 Part I Column 8 line 14 identifies total days, and based from the hospital's census workpapers included Labor & Delivery days. The Provider also is required to identify Labor and Delivery days specifically on Worksheet S-3 Part I line 32 column 8. The cost report includes a Worksheet to help calculate the allowable DSH percentage to be reported on Worksheet E Part A line 33, however, the DSH Worksheet calculation does not provide a mechanism to exclude Labor & Delivery days (as reported on S-3 Part I line 32

> column 8) if Labor & Delivery days are already included in Total Days (as is the case with this Provider). In this regard reporting Labor & Delivery days on Worksheet S-3, Part I, line 32, column 8 actually doubles the number of Labor & Delivery days in the allowable DSH percentage calculation. The Provider contends the Labor & Delivery days reported on S-3 Part I line 32 column 8 should only be added in if not included in Total Days. Labor & Delivery days should never be included twice for the allowable DSH percentage calculation because doing so artificially dilutes the Provider's DSH percentage. The Provider therefore contends that the [Medicare Contractor] erred by allowing the days in question to be counted twice for the purposes of the DSH adjustment.

On June 6, 2018, the Medicare Contractor filed a Jurisdictional Challenge over Issue 3. On June 29, 2018, the Provider timely filed a response to the Jurisdictional Challenge in compliance with Boar Rule 44.3 (July 2015).

On June 15, 2022, Issues 1 and 5 were withdrawn.

Medicare Contractor's Argument

In its Jurisdictional Challenge, the Medicare Contractor asserts that this issue does not meet the jurisdictional requirements because an adjustment was not made to the number of Labor and Delivery days. Instead, the Medicare Contractor accepted the as-filed numbers on Worksheet S-3, Part I, Column 8, Line 14 and Worksheet S-3, Part I, Column 8, Line 32 for the final cost report. The Medicare Contractor argues that the Provider cannot demonstrate dissatisfaction with the Medicare Contractor's final determination, as there was no Medicare Contractor final determination for this issue. The Medicare Contractor notes that the Provider is dissatisfied with its own reporting of Labor and Delivery days, not the Medicare Contractor's determination of the number of Labor and Delivery Days. Further, the Provider failed to preserve its right to claim dissatisfaction by including the reimbursement impact of these Labor and Delivery days as a Protested Amount on its as-filed cost report. The Medicare Contractor then lists all of the other opportunities that the Provider could have availed itself, but did not, to correct the amounts filed on the cost report, such as filing an amended cost report before the audit was performed or claiming such reimbursement as a Protested Amount, among others.

Provider's Response

In response, the Provider argues that the Medicare Contractor has an obligation to correctly and completely audit a provider's cost report, regardless of whether it benefits the Medicare program or the provider, citing to a provision in the Medicare Financial Management Manual (Pub. 100-06), Ch. 8, § 30.2, that states the primary goal in carrying out audit responsibilities is to arrive at a correct settlement of the cost report and in doing so, to preserve the provider's interests and rights. The Provider also cites to 42 C.F.R. § 421.100, which states with regard to the Medicare contractor's responsibilities, as follows: "[u]ndertaking to adjust incorrect payments and recover overpayments when it is determined that an overpayment was made."

The Provider argues that the Medicare Contractor ***should*** *have noticed* the Provider's error and made a corrective adjustment, and that it is not reasonable for a Medicare Contractor to rely on a provider's good faith error or misunderstanding of cost report instructions or flow, to then accept as-filed total days after being previously notified of the issue, and especially after actually reviewing the labor and delivery days at issue, and then claim the Provider is barred from disagreeing with the Medicare Contractor's own error in failing to adjust properly the as-filed cost report. The Provider states as follows:

> As noted on the face of the cost reporting forms for FYE 2011 or 2012, the Provider is required to report labor and delivery days separately on Line 32, column 8.00 of Worksheet S-3, Part I (Exhibit P-30). The labor and delivery days are then transferred automatically through the cost report to the Worksheet DSH, Line 23 (Exhibit P-29) and automatically added to Total Patient Days on Line 22 of Worksheet DSH. If labor and delivery days have already been included in Total Patient Days Line 14, column 8 of Worksheet S-3 (Exhibit P-30), there is no mechanism (other than a MAC [Medicare Contractor] adjustment) to remove them, and labor and delivery days are counted twice in the denominator of the Medicaid Fraction of the DSH adjustment, thereby reducing incorrectly the Provider's DSH percentage on Worksheet E, Part A, Line 33 (Exhibit P-39). The MAC does not contend that these days were not double counted. The MAC, therefore, admits that the Provider's DSH percentage is not, in fact, correct as audited. The MAC, however, made no effort to correct what should have been to it, an obvious error, even though it adjusted the Labor and Delivery days line item in Adjustment No. 6, and made specific changes to Line 32 on Worksheet S-3, Part I. Given that the Provider had notified the MAC in the transmittal to the as-filed cost report of an issue regarding non-removal of labor and delivery days from total days, the MAC cannot plausibly suggest that it had no responsibility to look at Worksheet S-3, Part I, Line 14 (total days) and Line 32 after making other changes to Line 32 (labor and delivery days), as it did in Adjustment No. 6 (and as flowed through to Adjustment No. 21).

Next, the Provider argues that it is appealing specific adjustments in which the Medicare Contractor adjusted labor and delivery days for the DSH calculation. The Provider explains that there actually was an adjustment of the Provider's DSH percentage in Adjustment No. 21, and there actually were adjustments to the labor and delivery days line items for the DSH calculation in Adjustment No. 4, and particularly, in Adjustment No. 6. As noted earlier, the Medicare Contractor specifically looked at labor and delivery days at least twice, in Adjustment Nos. 4 and 6, and changed the number on the labor and delivery days line on Worksheet S-3, Part I, Line 32 in Adjustment No. 6. Therefore, there is no basis for the Medicare Contractor to argue that the Provider has no jurisdictional ground to contest the number of labor and delivery days for DSH finalized through Adjustment Nos. 4, 6, and 21 on Worksheet S-3, Part I, Line 14. The Provider argues that at a minimum, it should be permitted to demonstrate its dissatisfaction with the DSH

percentage on the basis of the double counting of labor and delivery days, by challenging Adjustment Nos. 4, 6, and 21, which it did in this appeal.

Lastly, the Provider argues that it met all statutory appeal requirements applicable to it in this case, referring to the three requirements under 42 U.S.C. § 1395oo(a), which the Provider lists as (1) hospitals must be "dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of *total program reimbursement*," (2) at least $10,000 total must be in controversy in individual appeals, and (3) the hospitals must file an appeal within 180 days of the Medicare Contractor's final determination.

Applicable Authorities

A Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [1] and
- The amount in controversy is $10,000 or more.[2]

CMS Ruling CMS-1727-R

For purposes of Board jurisdiction over a Provider's appeal for cost report periods ending prior to December 31, 2008 the Provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the appealed issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[3] 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.[4]

On August 21, 2008, new regulations governing the Board were effective.[5] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which

[1] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[2] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[3] 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.).
[4] *Bethesda at 1258-59.*
[5] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[6] 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 expedited judicial review 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.[7]

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

Decision of the Board

The Board finds that it does not have jurisdiction over the Labor and Delivery Days issue, as the Provider has no basis to appeal this issue under 42 C.F.R. § 405.1835(a)(1) and CMS Ruling CMS-1727-R. Specifically, the Provider has no basis to be dissatisfied as there was no adjustment to the Labor and Delivery Days that are at issue, nor was there a protest item. The Provider's argument that Labor and Delivery Days were adjusted refers to Line 32 of Worksheet S-3, whereas the Provider's error was reporting these days in "total days" on Line 14, and the Medicare Contractor did ***not*** review the makeup of total days, nor did the Medicare Contractor adjust them, on Line 14. Rather, the Provider received the reimbursement for the Labor and Delivery Days at issue, as claimed. As a result, the Medicare Contractor had no way of knowing that the Provider made an error in reporting "total days" on Line 14. The Medicare Contractor cannot be expected to check and audit every item on the as-filed cost report but rather scopes a cost report for target items (*e.g.*, where certain specific costs are significantly out a line with the prior fiscal year).

Further, CMS Ruling CMS-1727-R is not applicable since the Provider did not self-disallow based on a good faith belief that the Labor and Delivery days at issue may not be allowable under Medicare payment policy. As described above, the Provider concedes that its dissatisfaction was the result of ***its own error*** stemming from a misunderstanding of the cost report form, itself. There was no regulation or other payment policy that prevented the Medicare

[6] 201 F. Supp. 3d 131 (D.D.C. 2016)
[7] *Banner* at 142.

Contractor from making payment in the manner now sought by the Provider, as there was nothing preventing the Provider from properly reporting the Labor and Delivery Days at issue. Specifically, had the Provider followed the cost report instructions and properly reported and claimed Labor and Delivery Days, it would have been reimbursed as sought through this appeal. In this regard, the cost report instructions in effect for FY 2011 are clear that Labor Room and Delivery Days are ***not*** to be included in Line 14 of Worksheet S-3.[8]

For these reasons, the Board finds that it does not have jurisdiction over this issue and dismisses it from the case. There are two issues remaining in this case; therefore, the case will remain open. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

[8] Provider Reimbursement Manual 15-2 § 4005.1 (Rev. 2, Aug. 2011) (stating "Line 14—Enter the sum of lines 7 - 13 for columns 2 - 8, and for columns 12 - 15, enter the amount from line 1. For columns 9 - 11, enter the total for each from your records. *Labor and delivery days* (as defined in the instructions for line 32 of Worksheet S-3, Part I) *must **not** be included on this line*." (bold and italics emphasis added); and, in contrast, stating "Line 32— Indicate in column 7 the count of labor/delivery days for Title XIX and in column 8 the total count of labor/delivery days for the entire facility. . . .").

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision***
Sutter Delta Medical Center (05-0523) FYE 12/31/2013
FYE: 12/31/2013
Case No.: 17-0466

Dear Mr. Jaeger and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-0466, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). In addition, the Board reviewed two additional issues on its own motion. The Board's decision is set forth below.

Background

A. Procedural History for Case No. 17-0466

On November 3, 2016, Sutter Delta Medical Center's ("Sutter" or "Provider"), appealed a Notice of Program Reimbursement (NPR) dated June 2, 2017, for its fiscal year dating December 31, 2013 ("FY 2013"). The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage Understated - Realignment
- Issue 2: DSH SSI Percentage Understated - Inaccurate Data
- Issue 3: DSH SSI Part C Managed Care Days in SSI Ratio
- Issue 4: DSH SSI Part A Pay Days in SSI Ratio
- Issue 5: DSH SSI MMA Section 951 Applicable to SSI Ratio
- Issue 6: DSH Code 2&3 w/o State Aid Code
- Issue 7: DSH Code MB 2&3 w/o State Aid Code
- Issue 8: Medicare DSH Understated Dual HMO Part C
- Issue 9: Medicare DSH Understated Dual HMO Part A
- Issue 10: Medicare DSH Understated In-State Eligible Days
- Issue 11: DSH Understated by Uncompensated Care

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Nov. 3, 2016).

- Issue 12: Midnight Rule
- Issue 13: HIT Payments Understated Due to Part C Days
- Issue 14: HIT Payments Understated Due to Charity Care

As the Provider is owned by Sutter Health, Issues 2 through 9 were transferred to Common Issue Related Party ("CIRP") Group Cases in compliance with the mandatory CIRP group requirements in 42 C.F.R. § 405.1837(b)(1). As a result, only 6 issues remains pending in this appeal – Issues 1, 10, 11, 12, 13, and 14.

On July 24, 2017, the Provider filed its preliminary position paper. On July 13, 2018 the Medicare Contractor filed its preliminary position paper.

On April 23, 2018, the Medicare Contractor filed a Jurisdictional Challenge, regarding Issue 1, addressing the DSH SSI Percentage (Provider Specific) issue, Issue 11, the DSH – Uncompensated Care issue, and Issue 12, the Two Midnight Reduction issue.[2]

Significantly, the Provider failed to respond to the Jurisdictional Challenge with the 30-day time period allotted under Board Rule 44.3 (July 2015):

> Unless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within thirty days from the date that the motion was sent to the Board and opposing party.

Finally, on its own motion, the Board will address its jurisdiction over Issues 13 and 14, the EHR/HIT Incentive payment issues.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0735GC

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

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

[2] MAC's Jurisdictional Challenge, at 1 (Apr. 23, 2018).

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

As the Provider is commonly owned by Sutter Health, the Provider was also transferred to the CIRP group under Case No. 18-0735GC entitled "Sutter Health 2013 DSH SSI Ratio Accurate Data CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
> 1. Unidentified Medicare beneficiaries who have exhausted their Part-A coverage;
> 2. Varied treatment of Medicare beneficiaries who are covered under Medicare Part-C;
> 3. Medicare Part-A beneficiaries in the SSI Percentage who are not included on the Medicare PS&R;
> 4. Medicare beneficiaries who are receiving SSI benefits but are not treated as such in the SSI Percentage;

[3] Provider's Request for Hearing, Issue Statement (Nov. 3, 2016).

5. The use of incorrect health insurance claim numbers for matching SSI recipients;
6. The total Medicare days reported in the denominator of the SSI ratio are often under reported.[4]

The amount in controversy listed for the Provider as a participant in 18-0735GC is $220,262.

On July 24, 2017, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

The preliminary position paper notes the amount in controversy as $110,542.

MAC's Contentions

Issue 1 – DSH SSI Percentage Understated - Realignment

[4] Group Issue Statement, Case No. 18-0735GC.

The MAC contends that the issue being challenged is the Realignment of the SSI percentage for the Disproportionate Share Hospital (DSH) payment. On its as-filed cost report, the Provider reported its SSI percentage based on the federal fiscal year end of September 30, pursuant to 42 C.F.R. 412.106(b)(2). For this issue, the Provider is not disputing the accuracy of the SSI percentage issued by CMS; the Provider is requesting to change the Medicare fraction computation from the federal fiscal year to its own cost reporting fiscal year.

The MAC requests that the PRRB dismiss this issue. The MAC did not render a determination of the realignment issue. Thus, the PRRB does not have jurisdiction over this issue.[5]

Issue 11 – DSH – Uncompensated Care

The MAC is challenging jurisdiction of the issue Disproportionate Share Hospital (DSH) Payment for Uncompensated Care (UCC), as administrative and judicial review of DSH UCC is precluded by Law and Regulation.

The MAC argues that the Provider is challenging the validity of the Secretary's determination of its disproportionate share hospital (DSH) payments for uncompensated care costs for FFY 2014 as published in the August 19, 2013 FFY 2014 Medicare IPPS Final Rule.[6] This Final Rule continued to implement 42 U.S.C. § 1395ww(r), the new DSH payment for uncompensated care. Congress, in enacting 42 U.S.C. § 1395ww(r)(3), explicitly barred administrative and judicial review of the new DSH payment methodology. Since Board review of the issue under dispute is barred, the Board does not have jurisdiction over this appeal. The Board is without authority to decide the issues raised by the Provider in this appeal.

Issue 12 – Two Midnight Reduction

This issue challenges the accuracy of the IPPS standardized payment rate for its FFY 2014 Medicare reimbursement, because of a 0.2% reduction attributed to the "2 midnight rule" first applied to FFY 2014 payments.[7]

Through its rule making authority and consistent with the *Shand*'s remand, CMS has established a correction applicable to the 2014 through 2016 complaints about the 0.2% reduction attributable to the "2-midnight rule". Further, through its rule making authority, CMS determined that it was the most administratively feasible approach, after entertaining many comments, to implement the correction in FFY 2017. That decision divests the Board of authority to consider relief in a FFY 2014 Appeal.[8]

The MAC is aware that in other "2 midnight rule" cases, the Board has dismissed Appeals under the EJR procedures either on request of the Provider or on the Board's own motion. As argued above, it is the MAC's position that the basic elements of Board jurisdiction are missing. Should

[5] *Id*. at 1, 6.
[6] *Id*. at 7.
[7] MAC's Jurisdictional Challenge, at 11.
[8] *Id*. at 13.

the Board reject this jurisdictional challenge, the MAC would expect that EJR proceedings would be initiated.[9]

Provider's Response

The Provider did not file a response to the jurisdictional challenge. As previously noted, Board Rule 44.3 (July 2015) which specifies: "Unless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within thirty days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision

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

A. Dismissal of Issue 1 -- DSH SSI Ratio/SSI Realignment

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly filed into Group Case No. 18-0735GC, Sutter Health 2013 DSH SSI Ratio Accurate Data CIRP Group.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 18-0735GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] The DSH systemic issues filed into

[9] *Id*. at 14.
[10] Individual Appeal Request, Issue 1.
[11] *Id.*
[12] *Id.*

Case No. 18-0735GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-0735GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 18-0735GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Indeed, in its appeal request, the Provider stated that this issue was subject to the CIRP group requirements since it was a common issue but *failed* to transfer the issue prior to filing its preliminary position paper in compliance with Board Rule 12.11 (Nov. 1, 2021).[13] Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged understatement is "provider specific" can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0735GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0735GC, but instead referred generically to an alleged "understatement" of the SSI percentage. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "understatement" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the any relevant documents (e.g., MEDPAR data) are unavailable. In this regard, Board Rule 25.2.2 specifies:

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[13] Board Rule 12.11 (Nov. 1, 2021) states, in pertinent part: "For those providers under common ownership or control, the transfer should take place upon identification of another provider that triggers the mandatory group requirement, but no later than the filing of the preliminary position paper."

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Accordingly, based on the record before it, the Board must find that Issues 1 and the group issue in Group Case 18-0735GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative and independent basis, the Board would dismiss Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with 42 C.F.R. § 405.1853(b)(2)-(3).

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

2. Second Aspect of Issue 1

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

B. Dismissal of Issue 11 – DSH – Uncompensated Care

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

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[17]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a) Tampa General v. Sec'y of HHS

[17] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[18] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[19] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[20] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[21]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[22]

b) DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[23] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[24] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is

[18] 830 F.3d 515 (D.C. Cir. 2016).
[19] 89 F. Supp. 3d 121 (D.D.C. 2015).
[20] 830 F.3d 515, 517.
[21] *Id.* at 519.
[22] *Id.* at 521-22.
[23] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[24] *Id.* at 506.

"inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[25]

c) Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[26] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[27] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[28] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[29] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[30]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[31]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he

[25] *Id.* at 507.
[26] 514 F. Supp. 249 (D.D.C. 2021).
[27] *Id.* at 255-56.
[28] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[29] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[30] *Id.*
[31] *Id.* at 262-64.

chose the wrong data or selected the wrong period."[32] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[33] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[34]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[35] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d) Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[36] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[37] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[38] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[39] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[40]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2014 UCC payments. The Providers here are challenging their uncompensated care DSH

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[32] *Id.* at 265.
[33] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[34] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[35] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[36] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[37] *Id*. at *4.
[38] *Id.* at *9.
[39] 139 S. Ct. 1804 (2019).
[40] *Ascension* at *8 (bold italics emphasis added).

Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. For these reasons, the Board dismisses Issue 11, DSH Uncompensated Care.

C. Required Action on Issue 12 – Two Midnight

The Provider states this issue as:

> In 2013 CMS announced the so-called two-midnight rule to clarify when it expected a patient to be designated to inpatient status. Under this rule, only patients that the doctor expects will need to spend two nights in the hospital would be considered as hospital inpatients. The Midnight 0.2 Reduction-The Secretary improperly exercised the authority granted to her through 42 U.S.C. 1395ww(d)(5)(1)(i), did not provide adequate notice and comment under the Administrative Procedure Act and otherwise acted arbitrarily and capriciously by improperly reducing Inpatient Prospective Payment System ("IPPS") and hospital specific payments, including operating, capital and any other aspect of the IPPS payments that was affected by the 0.2% reduction and all the components therein, to IPPS hospitals, sole community hospitals and Medicare dependent hospitals, including this Provider, for all inpatient stays for FFY 2014by 0.2% in light of the Secretary's adoption of the "two-midnight" policy, effective October 1, 2013. The secretary instead should have imposed a positive rather than a negative adjustment under 42 U.S.C. 1395ww(d)(5)(l)(i), because the two-midnight policy reduces IPPS expenditures.

As explained above, this Provider is commonly owned by Sutter Health, and the Two Midnight issue is a legal challenge that is generally pursued in group appeals. As explained in Board Rule 12.11, the Provider was required to transfer all CIRP issue to an appropriate CIRP group ***prior to*** *filing its preliminary position paper on July 24, 2017*. The Provider's representative needs to come into compliance with Board Rule 12.11 and, ***within twenty-one (21) days from this letter's signature date***, must consult and coordinate with Sutter and, after that consultation/coordination, either: (1) transfer this Provider to a newly formed Sutter CIRP group for this issue; (2) certify that no other Sutter providers are pursuing or will pursue/appeal this same issue for this same year; or (3) withdraw the issue. *Failure to comply with this deadline will result in the dismissal of this issue consistent with the Board's authority under 42 C.F.R. § 405.1868(a)-(b).*

D. Dismissal of Issues 13 and 14 – HIT Payments Understated Due to Part C Days; HIT Payments Understated Due to Charity Care

On February 17, 2009 the $787 Billion, the American Recovery and Reinvestment Act of 2009 was signed into law by the federal government. Included in this law is $22 Billion of which $19.2 Billion is intended to be used to increase the use of Electronic Health Records ("EHR") by physicians and hospitals; this portion of the bill is called, the Health Information Technology for Economic and Clinical Health Act, or the HITECH Act. Title XIII in Division A, pages 112 through 165 and Title IV in Division B, pages 353 through 398, cover the HITECH Act portion of this economic recovery act.

The Provider notes:

> In accordance with the American Recovery and Reinvestment Act (ARRA) of 2009, section 4102, inpatient acute care services under IPPS (providers subject to section 1886(d) of the Act) and CAHs are eligible for health information technology (BIT) payments."[41]

The provider is appealing Issue 13, the Understatement of HIT payments due to the understatement of Medicare Part C days on the PS&R report. The provider claims it did not have adequate information (such as the Medicare HIC number) associated with the Part C patients to be able to bill the claim to the Medicare Program. It protested the item to Worksheet B, Part A, Line 75 due to the fact there is no protest line available on Worksheet E-1, Part II.[42]

Similar to Issue 13, the provider is appealing Issue 14, the Understatement of HIT payments due to revisions and/or updates to hospital charity care charges, days, payments or other related service that occur after the filing of the Medicare cost report. It protested the item on Worksheet E, Part A, Line 75 due to the fact there is no protest line available on Worksheet E-1, Part II.[43]

The Board finds that it does not have jurisdiction over the HIT/EHR payment issues in the because jurisdiction is precluded by 42 U.S.C. § 1395ww(n) and 42 C.F.R. § 495.110(b).

42 U.S.C. § 1395ww(n) provides for incentives for adoption and meaningful use of certified EHR technology. Section 1395ww(n)(4)(A) states the following:

> **(4)Application.—**
>
> (A)Limitations On Review.— There shall be no administrative or judicial review under section 1395ff, section 1395oo, or otherwise, of-
>
> (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection

[41] Provider's Request for Hearing, Tab 3, at Issue Statement; PRM 15-IT, §4031.1.
[42] Provider's Request for Hearing, Tab 3, at Issue Statement.
[43] *Id*.

> (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);
>
> (ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and
>
> (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

The regulations at 42 C.F.R. § 495.110(b) also precludes administrative and judicial review under §§ 1395ff or 1395oo, or otherwise, of the following:

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

Here, this regulation precludes the Board's review of understatement of Part C days on the PS&R report (Issue 13) and charity care charges, days or payments (Issue 14) because review of estimates or proxies for determining discharges, inpatient-bed-days, hospital charges, charity care charges, and Medicare share is precluded from review. The Board thus concludes that it does not have jurisdiction over Issue 13 and Issue 14 in the above referenced appeal because judicial and administrative review of the calculation is barred by statute and regulation, and dismisses these two issues.

****

The Board finds that Issue 1 is duplicative of the SSI Systemic errors being pursued in Case No. 18-0735GC, and that there is no final determination from which the Provider can appeal the SSI realignment issue, and dismisses the issue. The Board also finds that Issue 11, DSH Uncompensated Care, Issue 13, HIT Payments Understated Due to Part C Days, and Issue 14, HIT Payments Understated Due to Charity Care, have their review precluded by Statute and Regulation, and dismiss these issues.

Within twenty-one (21) days from this letter's signature date, the Providers' representative must either transfer the Two Midnight issue for FYE 2013 to a Sutter CIRP group for this issue, certify that no other Sutter providers are pursuing or will pursue/appeal this same issue for the

same year, or withdraw the issue. *Be advised that this filing deadline is **firm**.* Accordingly, failure to comply with this deadline will result in the dismissal of this issue consistent with the Board's authority under 42 C.F.R. § 405.1868(a)-(b).

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

Board Members Participating:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Merit Health Central (Provider No. 25-0072)
FYE 09/30/2015
Case No. 19-1293

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 19-1293*

On August 1, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

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

1. SSI Percentage (Provider Specific)
2. SSI Percentage[1]
3. SSI Fraction Medicare Managed Care Part C Days[2]
4. SSI Fraction Dual Eligible Days[3]
5. Medicaid Eligible Days
6. Medicaid Fraction Medicare Managed Care Part C Days[4]
7. Medicaid Fraction Dual Eligible Days[5]
8. Uncompensated Care Distribution Pool[6]

[1] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0588GC.
[2] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0589GC.
[3] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0584GC.
[4] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0591GC.
[5] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0585GC.
[6] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0587GC.

9. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is part of the health system, Merit Health Central, the Provider is subject to the common issue related party CIRP group regulation at 42 C.F.R. § 405.1837(b)(1) and transferred Issues 3, 4, 6, 7, and 8 to CIRP groups on August 23, 2019. As a result of these transfers, there are only 2 issues remaining in this appeal: Issue 1, the DSH – SSI Percentage (Provider Specific) issue; and Issue 5, the DSH – Medicaid Eligible Days issue.

On May 6, 2019, the Board issued the Acknowledgement and Critical Due Dates Notice. Among other things, this Notice set the deadline for the filing of preliminary position papers on September 12, 2019 for the Provider and on January 10, 2020 for the Medicare Contractor. The Notice gave the following instruction regarding the Provider's preliminary position paper:

> Provider's Preliminary Position Paper – For each issue, the position paper **must state the material facts that support the appealed claim**, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. This filing **must include any exhibits the Provider will use to support its position** and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. *See* **Board Rule 25**.[8]

On May 6, 2019, the Medicare Contractor filed a Jurisdictional Challenge, asserting that the Board should dismiss Issue 1. On Friday, June 7, 2019, the Provider filed its response, albeit untimely by 2 days since per Board Rule 44.4.3, the Provider has 30 days to file its response.

On September 6, 2019, the Provider filed its preliminary position paper. Similarly, on December 13, 2019, the Medicare Contractor filed is preliminary position paper.

On November 14, 2022, the Medicare Contractor filed a Jurisdictional Challenge, asserting that the Board should dismiss Issue 5. On December 14, 2022, the Provider timely filed its response to the Jurisdictional Challenge. On December 28, 2022, the Medicare Contractor filed its reply to the Provider's response.

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

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

[7] On August 23, 2019, this issue was transferred to PRRB Case No. 18-0592GC.
[8] (Bold and underline emphasis added.)

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[9]

The Provider described its DSH – SSI Percentage (Systemic Errors) issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days[10]

On September 6, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Mississippi and the Provider does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Mississippi and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2,

[9] Issue Statement at 1 (Jan. 15, 2019).
[10] *Id*. at 2.

> 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[11]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $33,426. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 18-0588GC.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DHS SSI% - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.[12]

[11] Provider's Preliminary Position Paper at 8-9 (Sept. 6, 2019).
[12] Jurisdictional Challenge #1 at 6 (May 6, 2019).

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board.[13]

Issue 3 – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed. . .
>
> Within their preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[14]

The Provider goes on to say that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[15]

Provider's Jurisdictional Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[16] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[17]

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

[13] *Id*. at 5-6.
[14] Jurisdictional Challenge #2 at 4 (Nov. 14, 2022).
[15] *Id*.
[16] Jurisdictional Response #1 at 1 (June 7, 2019).
[17] *Id*. at 2.

amount of DSH payments that it received for fiscal year 2015, as a result of its understated SSI percentage due to errors of omission and commission."[18]

Issue 5 – Medicaid Eligible Days

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[19] The Provider goes on to argue that

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> These impediments [preventing the Provider from obtaining the necessary support] are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes.[20]

The Provider goes on to assert that "[c]oncurrent with this letter . . . the Provider[is] sending to the MAC the listing of additional Medicaid eligible days" and that "[a] redacted version of this listing is being posted to the Board's portal." Accordingly, the Providers assert that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[21] However, the Board notes that the Provider did not file the promised redacted listing of Medicaid eligible days or even identify how many Medicaid eligible days are actually in dispute.

Finally, the Provider generically states that its operations were disrupted by the COVID-19 pandemic and that it continues to face challenges related to COVID-19. However, the Provider did not explain how those challenges affected the development of the Medicaid eligible days issue or its position paper filing.

Medicare Contractor's Reply to the Provider's Response to the Jurisdictional Challenge:

The Medicare Contractor states that the Board Rules were clear that the complete preliminary position paper needed to be filed since that rule change was effective for appeals filed on or after August 29, 2018 and the appeal to establish this case was filed 4 ½ months later on January 15, 2019. Accordingly, the Medicare Contractor concludes that the Providers' understanding and expectation that the preliminary position papers could be filed without fully developed positions and exhibits is clearly erroneous and without merit.

---

[18] *Id*.
[19] Jurisdictional Response #2 at 1 (Dec. 14, 2022).
[20] *Id*. at 2.
[21] *Id*.

The Medicare Contractor notes that it is not requesting that the Board deny jurisdiction due to a failure to claim the Medicaid days at issue, but rather is requesting that the Board dismiss the issue due to the Provider's failure to file preliminary position papers in accordance with Board Rules and effectively abandoning the issue by failing to identify any specific Medicaid eligible days in dispute with its position paper.

Board Analysis and Decision:

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

A. DSH SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was appealed in PRRB Case No. 18-0588GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[22] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[23] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[24]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 18-0588GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage,

[22] Issue Statement at 1.
[23] *Id.*
[24] *Id.*

the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 18-0588GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[25], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 18-0588GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[26] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0588GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0588GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[27] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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[25] PRRB Rules v. 2.0 (Aug. 2018).

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

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[28]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[29]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0588GC are the same issue. Because the issue is duplicative, and

[28] Last accessed February 24, 2023.
[29] Emphasis added.

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

2. Second Aspect of Issue 1

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

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

B. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 2 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[30]

[30] Individual Appeal Request, Issue 2.

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

The Provider's preliminary position paper suggested the listing was imminent by stating that the listing was "being sent under separate cover."[31] However, the promised listing has never been filed with the Board. Moreover, the Provider does not state the actual Medicaid eligible days in dispute but rather only includes the same "estimated impact" for the issue that was included with the appeal request.[32] The Provider later argued that there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[33]

Board Rule 7.3.1.2 (Nov. 2021) states:

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

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. Moreover, the Provider preliminary position paper failed to identify any actual Medicaid days in dispute or explain why it could not identify them due to unavailable documentation in compliance with Board Rule 25.2.2 (including an explanation of its efforts to obtain that documentation and when it would become available). The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[34]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the*

[31] Provider's Preliminary Position Paper at 8 (Sept. 6, 2019).
[32] The "estimated impact" filed with the appeal request estimated 100 Medicaid eligible days for a net impact of $39,702.
[33] Jurisdictional Response #2 at 1.
[34] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> *relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[35]

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

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

Similarly, with regard to position papers,[36] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[37] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[38]

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

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. The Provider is misplaced in believing it could file its listing with the final position paper since the Rules and regulations cited above regarding position papers were in effect well before August 29, 2018. Moreover, the Provider appears to be well aware of the August 29, 2018 revised rules since it complied with those changes and filed it complete preliminary position paper.

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[39] and, pursuant to Board Rule 25 and 42 C.F.R. § 405.1853(b)(2)-(3), the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to

[39] (Emphasis added).

why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The Provider's *belated* generic assertion in its December 14, 2022 filing that "practical impediments are preventing [it] from obtaining the necessary support" due to "the eligibility matching being unavailable ***at this time*** due to a change in the State's matching vendor changes"[40] is wholly inadequate because:

1. It failed to explain why it failed to include this information as part of its preliminary position paper in compliance with Board Rule 25.2.2 and fails to explain why this information was not available at the time it filed its preliminary position paper. The fact that "at this time" (i.e., as of December 14, 2022), it is not available does not mean that it was not available more than 3 years earlier when it filed its preliminary position paper in September 2019 when it promised one was being sent under separate cover. Indeed, it is unclear why the Provider has been unable to identify any actual Medicaid eligible days in dispute (whether that is one day or more).

2. Regardless, the statement fails to meet the requirements of Board Rule 25.2.2 since it did not describe its efforts to obtain the unavailable/missing documentation and when it would become available.

In summary, without any days identified in the position paper filing (or in the record even at this late date), the Board must assume that there are no actual days at issue and that the amount in dispute for this issue is $0.

Moreover, contrary to the Provider's assertion, the Provider has ***not*** attempted to cure this defect since the record still does not contain a listing of the Medicaid eligible days at issue.[41] Similarly, the Provider's reference to the COVID-19 pandemic has no relevance since the Provider's preliminary position paper was filed in 2019 well before the outbreak of the pandemic and the Board's issuance of Alert 19 and the Provider has failed to explain how its generic reference to the pandemic otherwise relates to its failure to comply with Board Rules and regulations and its development of the Medicaid eligible days issue.

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

****

[40] (Emphasis added.)
[41] Note, the Board is *not* ruling that, had the provider done so, it would have accepted the listing at this late date. This situation is not before the Board and, as such, is not part of this ruling.
[42] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 18-0588GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue and failed to develop the merits of that issue in its position paper in compliance with 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 19-1293 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:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

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

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RE: ***Board Decision***
Yakima Regional Medical and Cardiac Center (Prov. No. 50-0012)
FYE 06/30/2017
Case No. 21-0317

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 21-0317, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 21-0317

On November 18, 2020, Yakima Regional Medical and Cardiac Center's ("Yakima" or "Provider"), appealed a Notice of Program Reimbursement ("NPR") dated June 1, 2020, for its fiscal year end ("FYE") June 30, 2017 cost reporting period. The Provider appealed the following issues:[1]

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH Medicare Part C Days – SSI Fraction
- Issue 4: DSH Dual Eligible Days – SSI Fraction
- Issue 5: DSH – Medicaid Eligible Days
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction
- Issue 7: DSH Dual Eligible Days – Medicaid Fraction

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), all but two of the group issues were transferred to Common Issue Related Party ("CIRP") Group Cases. The

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Nov. 29, 2017).

two issues remain that remain are Issue 1, DSH SSI Percentage (Provider Specific), and Issue 3, DSH – Medicaid Eligible Days.[2]

On April 28, 2021, the MAC filed a Request for Information regarding Medicaid Eligible days from the Provider, specifically requesting an electronic listing of the Medicaid eligible days at issue and supporting documentation to support all of the days in dispute.[3] The Medicare Contractor requested the information within 45 days. The Provider did ***not*** file a response to this request.

On July 6, 2021, the Provider filed its Preliminary Position Paper.

On October 12, 2021, the Medicare Contractor filed a Jurisdictional Challenge on October 12, 2021, regarding Issue 1, addressing the DSH SSI Percentage (Provider Specific) issue. The Provider did not file a response to the Jurisdictional Challenge in compliance with Board Rule 44.4.3.

On October 26, 2021, the Medicare Contractor filed its preliminary position paper. As part of this filing, the Medicare Contractor requested that the Board dismiss the Medicaid eligible days issue due to the Provider's failure to develop the issue and specify the actual Medicaid eligible days at issue in compliance with Board Rules.

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

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

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

[2] MAC's Jurisdictional Challenge, at 1 (Oct. 12, 2021).
[3] MAC's Information Request – DSH Package (Apr. 28, 2021).

> include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

The Provider was also transferred into a mandatory group under Case No. 20-1332GC entitled "CHS CY 2017 HMA DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

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

The amount in controversy listed for the Provider as a participant in 20-1332GC is $36,000.

On July 6, 2021, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**

[4] Provider's Request for Hearing, Issue Statement (Nov. 18, 2020).
[5] Group Issue Statement, Case No. 20-1332GC.

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).

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

Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $36,000. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-1332GC.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 20-1332GC, *CHS CY 2017 HMA DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[7]

[6] Provider's Preliminary Position Paper, at 8-9 (Jul. 6, 2021).
[7] MAC's Jurisdictional Challenge, at 2.

Lastly, Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

Provider's Response

The Provider did not file a response to the jurisdictional challenge. As previously noted, Board Rule 44.4.3 which specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

MAC's Request for Dismissal of the Medicaid Eligible Days Issue

As part of its preliminary position paper, the Medicare Contractor requested that the Board dismiss the Medicaid eligible days issue because the Provider had failed to meet its burden of proof and failed to develop the issue as required under Board Rules governing position papers.

The MAC noted that, on December 3, 2020, the Board acknowledged the Provider's appeal request. On April 28, 2021, the MAC sent the Provider a letter requesting a DSH package.[8] The MAC proposed that it would like to possibly resolve the Medicaid Eligible days issue administratively by performing a review of the additional Medicaid eligible days. However, the MAC noted that they had yet to receive a DSH package and requested that the Provider send it the following information within 45 days:

1. An electronic list (in Excel format) of Medicaid days included on the filed cost report or which was submitted for audit. For each patient record on the list, please include the patient's name, patient account number, date of admission and discharge, birth date, Social Security number, medical record number, DRG, location of stay (PPS area, Rehab, SNF, Psych, Observation, Swing, etc.), days claimed per patient, and in total.
2. The electronic list (in Excel format) of the additional Medicaid days included in the appeal request. The list should include all necessary information as described in item 1 above.
3. Ensure all non-allowable days (including but not limited to: Dual eligible days, Medicare Part C days, general assistance days, unmet spend down days, duplicates days, etc.) are excluded from the list of additional days.
4. Documentation of Medicaid eligibility for each of the patients during their respective stays related to the additional days requested, in a searchable electronic format.
5. Documentation to support all additional days were related to a unit or ward of the hospital providing acute care services generally payable under the prospective payment system. This should also be submitted in a searchable electronic format.[9]

The MAC stated that it did not receive a response.

[8] MAC's Information Request – DSH Package (Apr. 28, 2021) (copy included as Exhibit C-2 attached to the MAC's preliminary position paper).
[9] *Id*. at 1.

Rather, when the Provider filed its preliminary position paper roughly 2 months later, on July 6, 2021, the Provider stated that the "listing [was] not included" but promised that the Medicaid eligible days listing was "being sent under separate cover." However, the MAC never received that listing and no listing was filed with the Board.

Accordingly, "the MAC asks that the Board dismiss [the Medicaid eligible days] issue from this case" because the Provider is required to file a fully developed position paper but the Provider has failed to submit any form of documentation to identify any Medicaid eligible days in dispute or explain why it has been unable to do so in compliance with Board Rules:

> The Provider's skeletal position papers failed to mention that documents are unavailable, let alone explain why they remain unavailable or state the efforts made to obtain the documents. The Provider's position papers are perfunctory in every sense of the word. The Provider's preliminary position paper clearly violates Board Rule 25 via 27 (including 25.1.1 and 25.2.2) and 42 C.F.R. § 405.1853(b)(2) by failing to set forth a fully developed narrative with relevant arguments, controlling authorities, and facts regarding the merits of the Provider's claims on the Medicaid eligible day issue, and did not include all exhibits related to the issue.[10]

Provider's Response to Request to Dismiss or File DSH Package Inquiry

As of the date of this letter, the Provider has not filed a response with the Board to this inquiry or to the motion to dismiss.

Board Analysis and Decision

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

A. SSI Provider Specific

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

1. First Aspect of Issue 1

[10] MAC's Preliminary Position Paper at 15.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly filed into Group Case No. 20-1332GC, CHS CY 2017 HMA DSH SSI Percentage CIRP Group.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 20-1332GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[11] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] The DSH systemic issues transferred to Case No. 20-1332GC similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $36,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 20-1332GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 20-1332GC which it was required to do since it is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1332GC.

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

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[15] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to*

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Accordingly, the Board must find that Issue 1 and the group issue in Group Case 20-1332GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. *Second Aspect of Issue 1*

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

B. DSH – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 3 as:

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

[16] (Last accessed Nov. 21, 2022.)
[17] (Emphasis added.)

> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[18]

The amount in controversy calculation and protested item documentation for this issue suggests that the number of Medicaid eligible days at issue. However, the Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

On July 6, 2021, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[19] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

[18] *Id*.
[19] Provider's Preliminary Position Paper, at 8 (Jul. 6, 2021).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

While the Calculation Support filed with their appeal notes a net "estimated impact" of $96,000, with an estimated increase of 100 days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper because the Provider's preliminary position paper fails to identify what, if any, Medicaid eligible days are in *actual* dispute. Rather, the preliminary position paper attached the same "*estimated* impact" as confirmed by the fact that the actual listing was promised to be send under separate cover.[20] However, that listing has not been forthcoming and has not ever been made part of the record before the Board.

Board Rule 7.3.1.2 (Nov. 2021) states:

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

Moreover, as the MAC has asserted in its DSH Package Information Request,[21] the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

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[20] (Emphasis added.)
[21] MAC's Information Request – DSH Package (Apr. 28, 2021).

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover to confirm what days are, in fact, in dispute. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[22]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[23]

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

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

Similarly, with regard to position papers,[24] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[25] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:

---

[22] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[23] (Emphasis added.)

[24] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[25] (Emphasis added.)

1. Identify the missing documents;
2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.[26]

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

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

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

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

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

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

The Board agrees with the Medicare Contractor that, as part of its preliminary position paper filing, the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable.

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

Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. As such, based on the record before it, the Board must find that there are no actual days at issue and the actual amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[28] The Board takes administrative notice that it has made similar dismissal in other cases in which Community Health Systems ("CHS") was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. The Board also dismisses Issue 3, DSH Medicaid Eligible days, as it is in violation of the Board Rules and regulations. As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Northwest Mississippi Regional Medical Center (Prov. No. 25-0042)
FYE 10/31/2017
Case No. 21-1445

Dear Messrs. Ravindran and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. ***Procedural History for Case No. 21-1445***

On January 11, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end October 31, 2017.

On July 1, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH – SSI (Provider Specific)
2. DSH – SSI (Systemic Errors)[1]
3. DSH – SSI Fraction Medicare Managed Care Part C Days[2]
4. DSH – SSI Fraction Dual Eligible Days[3]
5. DSH – Medicaid Eligible Days
6. DSH – Medicaid Fraction Medicare Managed Care Part C Days[4]
7. DSH – Medicaid Fraction Dual Eligible Days[5]

[1] On January 7, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On January 7, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On January 7, 2022, this issue was transferred to PRRB Case No. 20-1383GC.
[4] On January 7, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[5] On January 7, 2022, this issue was transferred to PRRB Case No. 20-1383GC.

As the Provider is owned by Community Health Systems ("CHS"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1) and transferred Issues 2, 3, 4, 5, and 7 to CHS CIRP groups. As a result, only 2 issues remain – Issue 1, the DSH – SSI (Provider Specific) issue; and Issue 4, the DSH – Medicaid Eligible Days issue.

On February 8, 2022, the Provider filed its preliminary position paper and, with respect to the Medicaid eligible days issue, stated that the Medicaid eligible days was "not included" but promised it was "being sent under separate cover." Further, the position paper did not identify the actual number of days in dispute but rather included the same "estimated impact" for this issue of $47,357 based on an *estimated* 40 days.

On May 10, 2022, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1 claiming it was duplicative of Issue 2 and should be dismissed. The Provider did not file a response within the 30-day time frame specified in Board Rule 44.4.5.

On June 3, 2022, the Medicare Contractor filed its preliminary position paper.

On November 14, 2022, the Medicare Contractor filed another Jurisdiction Challenge, requesting that the Board dismiss Issue 4 due to the Provider's failure to properly develop the issue in its position paper filing.

On December 14, 2022, the Provider timely filed its response to this second jurisdictional challenge in compliance with Board Rule 44.4.3.

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

In their Individual Appeal Request, Provider summarizes its DSH – SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

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

Provider described its DSH – SSI Percentage (Systemic Errors) issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days[7]

On February 8, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See*

[7] *Id*. at 2.

> *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[8]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $2,910. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-0997GC.

MAC's Contentions

Issue 1 – DSH – SSI (Provider Specific)

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[9]

Further, the MAC contends Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[10]

In addition, the MAC argues the DSH – SSI (Provider Specific) issue and the DSH – SSI (Systemic Errors) issue are considered the same issue by the Board.[11]

Issue 5 – DSH – Medicaid Eligible Days

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

---

[8] Provider's Preliminary Position Paper at 8-9 (Feb. 8, 2022).
[9] Jurisdictional Challenge #1 at 6-7 (May 10, 2022).
[10] *Id*. at 7-9.
[11] *Id*. at 4-6.

> The MAC contends that the Provider was in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed. . .
>
> Within their preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[12]

Accordingly, the MAC requested that the Board dismiss the Medicaid eligible days issue.

Provider's Jurisdictional Response

Issue 1 – DSH – SSI (Provider Specific)

The Provider did not file a response to the jurisdictional challenge over this issue.

Issue 5 – DSH – Medicaid Eligible Days

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[13] The Provider goes on to argue that

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional

[12] Jurisdictional Challenge #2 at 4 (Nov. 14, 2022).
[13] Jurisdictional Response at 1 (Dec. 14, 2022).

> Medicaid eligible days for providers not impacted by practical impediment.[14]

The Provider goes on to assert that "[c]oncurrent with this letter . . . the Provider[is] sending to the MAC the listing of additional Medicaid eligible days" and that "[a] redacted version of this listing is being posted to the Board's portal." Accordingly, the Providers assert that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[15] However, the Board notes that the Provider did not file the promised redacted listing of Medicaid eligible days or even identify how many Medicaid eligible days are actually in dispute.

Finally, the Provider generically states that its operations were disrupted by the COVID-19 pandemic and that it continues to face challenges related to COVID-19. However, the Provider did not explain how those challenges affected the development of the Medicaid eligible days issue or its position paper filing.

Board Analysis and Decision:

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

A. DSH – SSI (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH – SSI (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

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

The DSH – SSI (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal basis for its DSH – SSI

[14] *Id*. at 2.
[15] *Id*.
[16] Issue Statement at 1.

(Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH – SSI (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH – SSI (Provider Specific) issue in this appeal is duplicative of the DSH – SSI (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH – SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the

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[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2.0 (Aug. 2018).
[20] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

alleged fact is,[21] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[22]
> This CMS webpage describes access to DSH data ***from 1998 to***

[21] There are no exhibit or citations to state records or examples of how SSI entitlement can be ascertained from state records.
[22] Last accessed February 24, 2023.

> ***2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

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

2. Second Aspect of Issue 1

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

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

B. DSH – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

[23] Emphasis added.

> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[24]

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

The Provider's preliminary position paper promised that it would be sending the eligibility listing under separate cover.[25] But failed to do so. Moreover, it did not state the precide number of days at issue but rather included the same "*estimated* impact"[26] calculation that was included in with the appeal request. In its response to the Jurisdictional Challenge, the Provider is now belatedly arguing that, "at this time," there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[27]

Board Rule 7.3.1.2 (Nov. 2021) states:

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

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[28]

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

---

[24] Individual Appeal Request, Issue 5.
[25] Provider's Preliminary Position Paper at 8.
[26] (Emphasis added.)
[27] Jurisdictional Response at 1.
[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[29]

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

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

Similarly, with regard to position papers,[30] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[31] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[32]

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

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. The Provider is misplaced in believing it could file its listing with the final position paper since the Rules and regulations cited above regarding position papers were in effect well before August 29, 2018. Moreover, the Provider appears to be well aware of the August 29, 2018 revised rules since it complied with those changes and filed it complete preliminary position paper.

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules.

[33] (Emphasis added).

Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The Provider's *belated* generic assertion in its December 14, 2022 filing that "practical impediments are preventing [it] from obtaining the necessary support" due to "the eligibility matching being unavailable ***at this time*** due to a change in the State's matching vendor changes"[34] is wholly inadequate because:

1. It failed to explain why it failed to include this information as part of its preliminary position paper in compliance with Board Rule 25.2.2 and fails to explain why this information was not available at the time it filed its preliminary position paper. The fact that "at this time" (i.e., as of December 14, 2022), it is not available does not mean that it was not available more than 3 years earlier when it filed its preliminary position paper in September 2019 when it promised one was being sent under separate cover. Indeed, it is unclear why the Provider has been unable to identify any actual Medicaid eligible days in dispute (whether that is one day or more).

2. Regardless, the statement fails to meet the requirements of Board Rule 25.2.2 since it did not describe its efforts to obtain the unavailable/missing documentation and when it would become available.

In summary, without any days identified in the position paper filing (or in the record even at this late date), the Board must conclude that there are no actual days in dispute and that the amount in controversy is, in fact, $0.

Moreover, contrary to the Provider's assertion, the Provider has ***not*** attempted to cure this defect since the record still does not contain a listing of the Medicaid eligible days at issue.[35] Similarly, the Provider's reference to the COVID-19 pandemic has no relevance since the Provider's preliminary position paper was filed in 2019 well before the outbreak of the pandemic and the Board's issuance of Alert 19 and the Provider has failed to explain how its generic reference to the pandemic otherwise relates to its failure to comply with Board Rules and regulations and its development of the Medicaid eligible days issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[36]

****

[34] (Emphasis added.)
[35] Note, the Board is *not* ruling that, had the provider done so, it would have accepted the listing at this late date. This situation is not before the Board and, as such, is not part of this ruling.
[36] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

In summary, the Board hereby dismisses the DSH – SSI (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue and failed to develop the merits of that issue in its position paper in compliance with 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-1445 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

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

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Tennova Healthcare – Lafollette Medical Center (Prov. No. 44-0033)
FYE 09/30/2017
Case No. 22-0784

Dear Mr. Summar and Ms. Huggins:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0784 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 22-0784*

On February 14, 2022, Tennova Healthcare – Lafollette Medical Center filed its appeal of the Notice of Program Reimbursement ("NPR") dated August 20, 2021, for its fiscal year end September 30, 2017. The appeal request contained the following issues:

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

As the Provider is part of Community Health Systems, Inc. ("CHS"), the Provider transferred issues 2, 4, and 5 to common issue related party ("CIRP") groups for CHS in compliance with the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). As a result, only two issues remain in this appeal – Issues 1 and 3.

[1] On September 8, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On September 8, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On September 8, 2022, this issue was transferred to PRRB Case No. 20-1383GC.

On October 3, 2022, the Provider filed its preliminary position paper.

On January 13, 2023, the Medicare Contractor filed a Jurisdictional Challenge regarding the remaining 2 issues on appeal, the DSH/SSI Percentage (Provider Specific) issue and the DSH Medicaid eligible days issue.

On January 20, 2023, the Medicare Contractor filed its preliminary position paper.

Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies:

> Providers must file a response within thirty (3) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

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

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[4]

The Provider contends that its SSI percentage published by ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[5] The amount in controversy was listed as $8,473.[6]

In the SSI percentage issue in CIRP group case 20-0997GC, which includes the Provider in this case, and the same fiscal year, the Providers assert that:

> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C.

[4] Provider's Request for Hearing, Issue 1 Issue Statement (Feb. 14, 2022).
[5] *Id.*
[6] *Id.*

> §1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[7]

The amount in controversy for Provider No. 44-0033 in Case No. 20-0997GC is $8,473, the same amount as issue #1 in the individual appeal.

On October 3, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Tennessee and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Tennessee and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2,

[7] *Id*. at 2.

> 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of those errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[8]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $8,473. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-0997GC.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DHS SSI% - Provider Specific issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The realignment component should be dismissed. There was no final determination over the SSI realignment. The Provider's appeal is premature as the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[9]

[8] Provider's Preliminary Position Paper at 8-9 (Oct. 3, 2022).
[9] Jurisdictional Challenge at 7-8 (Jan. 13, 2023).

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board, and cites several past Board decisions to that end.[10]

Lastly, the MAC contends Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[11]

Issue 5 – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[12]

The MAC contends the provider has abandoned the issue because the Provider has never submitted to the MAC a listing of the Medicaid eligible days at issue and was required to do so as part of its preliminary position paper, even though this appeal pertains to the 2017 fiscal year that ended over 5 years ago.

Provider's Response

The Provider did not file a response to the jurisdictional challenge. As previously noted, Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via

[10] *Id*. at 6-7.
[11] *Id*. at 8-10.
[12] *Id*. at 12.

a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

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

A. DSH SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

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

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 20-0997GC. Because the issue is duplicative,

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

and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC which the Provider was required to do per the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[18] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and

[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[18] There are no exhibit or citations to state records or examples of how SSI entitlement can be ascertained from state records.

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[19]16
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[20]

Accordingly, the Board finds that Issue 1 in the instant appeal and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

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

B. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[21]

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

On October 3, 2022, the Provider filed their preliminary position paper in which it indicated that it could be sending the eligibility listing under separate cover.[22] As of the filing of the jurisdictional challenge in January 2023, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days, though their Calculation Support filed with their appeal

[21] Individual Appeal Request, Issue 3.
[22] Provider's Preliminary Position Paper at Exhibit 1.

notes a net impact of $2,569, with an increase in days. To date, the Provider has not responded to the challenge alleging the listing was submitted as required, nor has the Board been notified by either party that the listing was eventually submitted.

Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2018 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[23]

[23] *Id.* at 7-8.

In its jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $2,569, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.1.2 (Nov. 2021) states:

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

Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submit such list under separate cover as it had promised. Indeed, the Provider does not identify the actual days at issue but rather only attached the original "*estimated* impact"[24] statement of $2,569 (based on an *estimated* 40-day increase) that was included with the appeal request. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[25]

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

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

[24] (Emphasis added.)
[25] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[26]

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

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

Similarly, with regard to position papers,[27] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[28] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[29]25

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

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

---

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[30] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any actual days identified in the position paper filing, the Board must assume that, based on the record before it, there are, in fact, no days in dispute and that the actual amount in controversy is $0 for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[31]

****

[30] (Emphasis added).
[31] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 22-0784 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

4/3/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Re: ***Dismissal Based On Lack of Substantive Jurisdiction***
19-1723GC Ardent Health FFY 2019 Understated IPPS Standardized Amount CIRP Group
19-1735GC Lifepoint Health FFY 2019 Understated IPPS Standardized Amount CIRP Group
19-1763GC CHS FFY 2019 Understated IPPS Standardized Amount CIRP Group
19-0233GC Quorum Health FFY 2019 IPPS Understated Standardized Payment Amt. CIRP
19-1628GC Archbold FFY 2019 Understated IPPS Standardized Amount CIRP Group

Dear Mr. Jenkins:

As you are aware, by letter dated October 27, 2021, the Provider Reimbursement Review Board ("Board") denied the request for Expedited Judicial Review ("EJR") filed by the Providers' representative, Hospital Reimbursement Group ("HRG") in the above-captioned common issue related party ("CIRP") group cases on August 10, 2020.[1] Within that same letter, the Board requested the parties to brief a number of issues relating to the Board's jurisdiction over the matter raised in these appeals as well as the sufficiency of the record for these cases. Pursuant to Board Scheduling Orders, the parties responded to the Board's requests and filed briefs with supporting documentation where the last responsive brief was filed on March 18, 2022. As set forth below, the Board has completed its review and, consistent with 42 U.S.C. § 1395ww(d)(7) and 42 C.F.R. § 405.1840(b), is dismissing these cases for lack of substantive jurisdiction.

Group Issue Appealed:

The issue statement set forth in the group appeal request filed to establish Case Nos. 19-1763GC, 19-1735GC, 19-1723GC, and 19-1628GC is:

> [W]hether the hospitals have been underpaid for the periods covered by the 2019 federal fiscal year because the inpatient

[1] The Board's October 27, 2021 EJR denial and Request for Information pertained to 6 CIRP groups and, in denying the EJR, the Board stated: "[T]he extent and complex nature of the Board's questions, as set forth below, make clear that, pursuant to 42 C.F.R. § 405.1842(f)(2)(iii), there is insufficient information in the record to determine jurisdiction and to determine whether granting the Provider's EJR request is appropriate. . . . Accordingly, the Board hereby **denies** the Providers' EJR request. The Providers may re-file the EJR request, as appropriate, *following further development of the record*." (Italics emphasis added.) The Board is aware that in the other *unrelated* FFY 2019 CIRP group case (Case No. 19-0710GC) for which HRG is the group representative, another EJR request was filed. However, HRG has ***not*** filed another EJR request in these 5 CIRP group cases.

> hospital prospective payment system (PPS) standardized amounts are understated for the 2019 federal year due to the Secretary's failure to properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts.

Similarly, the issue statement set forth in the group appeal request filed to establish Case No. 19-0233GC is:

> **Statement of the Issue**:
>
> Whether the Secretary properly calculated the Providers' Standardized Payment Amount [as used in the payment rates for the FFY 2019 PPS].
>
> **Statement of the Legal Basis**
>
> This appeal is taken from the Secretary's final determination of the payment rates under PPS for FY 2019. See 83 Fed. Reg. 41709-41715, August 17, 2018. . . .
>
> Under the Inpatient Prospective Payment System, hospitals are paid a fixed amount for each Medicare beneficiary that they treat, "regardless of the actual operating costs they incur." See Sebelius v. Auburn Reg'l Med. Ctr., 568 U.S. 145, 133 S. Ct. 817, 822, 184 L. Ed. 2d 627 (2013). Under the prospective payment system (PPS), this payment consists of the product of two figures: the applicable standardized amount multiplied by the DRG weights. *At issue in this appeal are errors in the computation of the standardized amount*.
>
> The standardized amount was initially computed in 1983 system using 1981 hospital cost report data. The standardized amount was developed on the basis of an average cost per discharge computation. 42 U.S.C. § 1395ww(d)(2). The base year 1981 data did not distinguish between patient discharges and patient transfers. Both were classified as discharges. Therefore, the 1981 data over-counted discharges, by including both discharges and transfers in the base year data.
>
> The result of this error was to spread total operating costs over an artificially high number of discharges, thereby yielding a lower average cost-per-discharge. This in turn lead to an initial computation of the standardized amount that was lower than it would have been had the total number of patient discharges been accurately computed.

> This initial computational error at the inception of the PPS has never been corrected. As each year's standardized amount is updated based on the previous year's amount, the standardized amount has been lower than it should have been in every year since the inception of PPS in 1984. See Saint Francis Med. Ctr. v. Azar, 894 F.3d 290 (D.C. Cir. 2018). Providers contend that it was arbitrary, capricious and inconsistent with law for the Secretary to fail to adjust the 1981 cost report data to reflect the correct number of Medicare discharges, and to provide appropriate revisions to the PPS standardized amount. 5 U.S.C. § 706(2)(A).[2]

Based on the above issue statements, it is clear that each of the 5 CIRP groups appealed the same issue. Specifically, the Providers in these 5 CIRP groups are alleging that: (a) the standardized payment amount used in the FFY 2019 inpatient prospective payment system for operating costs ("IPPS") payments rates is *understated* because the Secretary failed to properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts; and (b) the resulting understated initial base year amounts were carried forward ***across 35 years*** resulting in the alleged understated standardized amount used for setting the FFY 2019 IPPS payment rates. In this regard, the Board notes that, for FFY 1984, there were two standardized rates, one for urban hospitals and one for rural hospitals and Congress later directed the Secretary to eliminate the separate rates and establish one standardized rate beginning with FFY 1995.[3] As a result, for FFY 2019, there is only one standardized rate at issue.

Procedural Background:

HRG initially filed an EJR request for the 5 CIRP groups on August 10, 2020. Attached to the EJR request was an expert report wherein the purported expert was engaged to estimate the amount of "underpayments . . . caused by the failure of the Medicare program to properly account for patient transfers in the calculation of standardized amounts in federal fiscal year ("FFY") 1984, when IPPS was first implemented, which has caused underpayments for all subsequent FFYs."[4] Federal Specialized Services ("FSS") filed a response to the EJR request on August 25, 2020. In reviewing the EJR request, the Board determined that it needed additional information with respect to jurisdiction and, as a result, issued a Request for Information ("RFI") on September 9, 2020 and the parties filed responses on October 9, 2020 and November 6, 2020.

On October 27, 2021, the Board issued a determination for each of these 5 CIRP groups denying the EJR requests and requesting additional information regarding the issues raised in the appeals to allow the Board to determine whether: (1) the Board has substantive jurisdiction over the matter in the appeals; (2) the record is sufficiently developed; (3) there are material factual disputes, and; (4) EJR was an appropriate outcome. Taking into consideration the complex

[2] (Emphasis added.)
[3] *See infra notes* 68 and 69 and accompanying text (discussing the statute and associated legislation eliminating the two separate standardized amounts and establishing one standardized amount effective FFY 1995).
[4] Providers' EJR Request (Aug. 10, 2020), Exhibit D at 1.

nature of the dispute, the novel jurisdictional questions raised by that dispute and the extensive amount of analysis and information requested in its RFIs, the Board stated that it, "believe[d] that the parties may need at least 3 months to consider the Board's questions before filing a response." With that in mind, the Board then directed the parties to confer and jointly propose a briefing schedule to allow time for comprehensive responses.

On November 16, 2021, the parties proposed that they would simultaneously file their responses to the Board's RFI on January 7, 2022 and any optional responses to the other party's January 7 filing would be due by February 8, 2022. No objections to the Board's RFI were filed at that point.

On November 24, 2021, the Board established January 21, 2022 as the due date for the simultaneous filings and set March 4, 2022 for the responses, if any, explaining that "[d]ue to the complexity of the issues to be briefed and the intervening holidays, the Board . . . opted to extend by roughly two weeks the briefing time frames proposed by the parties to ensure the parties have sufficient time to research and adequately address the concerns raised in the Board's October 27th letter."

On November 12, 2021, unbeknownst to the Board, the Providers filed a request with the Administrator asking that she: (1) review the jurisdictional component of the Board's October 27, 2021 EJR denial; (2) find that the Board has jurisdiction over the group appeals; and (3) order the Board to determine whether it has legal authority to decide the single issue under appeal in these group appeals. On December 22, 2021, the Administrator declined to review and the Providers did not pursue further action in federal court.

On January 19, 2022, HRG filed an unopposed request for a two-week extension to the entire briefing schedule for responses to the RFI and stated that the Board's concerns about ensuring the parties had sufficient time to adequately address the Board's RFI "have proved prescient." On January 21, 2022, the Board granted the 2-week extension to February 5, 2022 and set March 18, 2022 for the responses, if any.

On February 4, 2022, the lead Medicare Contractors filed their response to the RFI. Similarly, on February 5, 2022, HRG filed its response to the RFI but, *for the first time* (over 3 months after the RFI was issued), included certain objections to the RFI within their response. On March 18, 2022, HRG filed a response to the Medicare Contractors' filing.

Providers' Response to the Board's October 27, 2022 RFI:

At the outset, the Providers' February 5, 2022 response suggested that the Board's RFI was unnecessary as they maintained that: (1) they had previously extensively briefed the Board's jurisdiction over the appeal and the Board's authority to grant the relief requested by the Providers; and (2) the prior briefing made clear the Board's jurisdiction but its lack of authority to decide the legal questions raised or to grant the relief sought. The Providers maintained that

many of the Board's questions were inappropriately vague or unduly burdensome, or inappropriately addressed the merit of the Providers' claims.

The Providers summarize their responses as follows:

> [T]he Providers' answers to the Board's questions below show (1) the statute means just what it says with respect to the meaning of "cost per discharge," (2) the predicate fact error in FFY 1984 has continued to affect payments to the Providers in the years on appeal, (3) the Board has jurisdiction over these Group Appeals, but lacks the authority to grant the relief sought, (4) there are no factual issues requiring resolution prior to EJR being granted, and (5) the Board's decision in *Columbia/HCA v. BCBS*, PRRB Dec. No. 2000-D74 (Aug. 18, 2000), does not apply to these Group Appeals.[5]

Of particular relevance to the Board's finding of a lack of jurisdiction is the Providers' response to Question 2 and its 5 sub-questions addressing how the base standardized amounts were updated annually and the impact of the FFY 1984 and 1985 budget neutrality adjustments on the issue in these 5 CIRP group appeals:

> B. Answers to the sub-questions in Question Two
>
> 1. [Sub-]Question: "[W]hether there is any statutory basis for" the quoted position of the Providers that "**CMS calculates standardized amounts for IPPS purposes for a given FFY by applying a cost inflation adjustment (and other percentage adjustments) to the standardized amount from the previous FFY.**" (at 7, emphasis in Board's Requests)
>
> Answer: Yes, there is a statutory basis for the Providers' position. The methodology for the calculation of the original FFY 1984 standardized amount was prescribed in 42 U.S.C. § 1395ww(d)(2)(A)–(C).[6] Section 1395ww(d)(3) generally provides that the standardized amount for each subsequent year is required to be "equal to the respective average standardized amount computed for the previous fiscal year," "increased for the applicable percentage increase" under subsection (b)(3)(B), and further adjusted by the necessary percentages to account for outliers and other matters. 42 U.S.C. § 1395ww(d)(3)(A)–(C).

[5] Providers' Consolidated Response to the Board's October 27, 2021 Denials of EJR and Requests for Information, 4 (Feb. 5, 2022) ("Providers' Response to the Board's RFI").
[6] The Providers cited these statutory provisions in their Preliminary Position Paper and referenced them in their Requests for EJR.

In other words, the statute requires that the standardized amount for an FFY is calculated based on the standardized amount for the prior FFY, with certain percentage adjustments.

This statutory construct has been recognized by the D.C. Circuit on multiple occasions. In *Cape Cod Hospital v. Sebelius*, 630 F.3d 203, 205 (D.C. Cir. 2011), the court cited the above statutes for the proposition that: "CMS does not calculate the standardized amount from scratch each year. Instead, following Congress's directive, it calculated the standardized amount for a base year and has since carried that figure forward, updating it annually for inflation." In *Saint Francis Med. Center v. Azar*, 894 F.3d 290, 291 (D.C. Cir. 2018), the court cited §1395ww(d)(3) for the proposition that: "Although prospective payment amounts are adjusted over time in various ways, the standardized amounts themselves are not. Those amounts were calculated in 1983, based on hospitals' cost-reporting data from 1981. To this day, therefore, Medicare payments for inpatient services depend in part on factual determinations derived from 1981 data and embedded in 1983 calculations, including the calculation of 'allowable operating costs per discharge.'" *See also id.* at 297 (Kavanaugh, J., concurring) ("HHS calculates hospitals' Medicare reimbursements by employing a formula predicated on statistics for hospital discharges in 1981.").

2. [Sub-]Question: "[W]hether the Secretary applied these statutory provisions in the below manner over the course of ***all intervening*** federal fiscal years from 1984 to the year(s) at issue."

Answer: Yes, the Secretary calculated the standardized amount in this manner for each year from FFY 1984 to the FFYs at issue in the Group Appeals. The standardized amount in each FFY from 1985 to 2022 was equal to the standardized amount for the prior FFY, adjusted by a certain percentage as required by statute.

3. [Sub-]Question: "[T]he Board would like the parties to confirm for each intervening year whether there are any factors or adjustments or changes that would eliminate, in whole or in part, the Providers' concerns regarding the effect of the 1981 cost data."

Answer: Because the Secretary has never addressed his failure to properly account for transfers when calculating the original IPPS standardized amount in FFY 1984, the Secretary has never addressed "the Providers' concerns regarding the effect of the 1981 cost data." Moreover, assuming for the sake of argument that the Secretary later proffered a "factor, adjustment, or change" that

"eliminate[d], in whole or in part," the Providers' challenge, such action would be relevant, if at all, only to determine the extent of the damages resulting from the Providers' challenge. Thus, this question is hypothetical, irrelevant to EJR, and unduly burdensome, because it does not implicate jurisdiction or the Board's authority.

4. [Sub-]Question: "Does the fact that, pursuant to 42 U.S.C. § 1395ww(e)(1), the Secretary was required to adjust the average standardized amounts for both 1984 ***and*** 1985 as necessary to ensure budget neutrality mean that any increase in the initial base cost per discharge rate (as advocated by the Providers) would be offset by any required budget neutrality adjustment for 1984 and/or 1985? If so, is the Providers' real issue that the budget neutrality adjustments were too low?"

Answer: As stated above, the issue in these Group Appeals is the Secretary's failure to properly account for transfers when calculating the original standardized amount in FFY 1984. This question asks, if the Secretary had properly accounted for transfers when calculating the original standardized amount in FFY 1984 by increasing the initial base cost per discharge, would that increase have been offset by the "required budget neutrality adjustment for 1984 and/or 1985," so that the "Providers' real issue [is] that the budget neutrality adjustments were too low."

****

The Board's Requests (at 8-9) quote the portion of the FFY 1984 IPPS Final Rule at 49 Fed. Reg. 234, 255 (Jan. 3, 1984), where the Secretary stated that a requested increase to the initial standardized amount would have been offset by a corresponding recalculation of the budget neutrality adjustment factor. The quoted discussion, however, is facially inapposite to the Group Appeals. Unlike the transfer adjustment, which the FFY 1984 IPPS Final Rule did not address, the requested increase discussed in the quoted section (related to certain cost shifting from Part B to Part A resulting from a recent regulation) had already been factored into the estimated per-discharge payments under prior law for purposes of budget neutrality adjustment in the FFY 1984 IPPS Final Rule.

The Board's Requests (at 9-10) also quote portions of 50 Fed. Reg. 35646, 35697 (Sept. 3, 1985), in which the Secretary discussed his position that he had the authority to carry forward prior budget neutrality adjustments and to correct for errors in budget neutrality adjustments in prior years. The quoted discussions are also inapposite to the Group Appeals because, as explained above, a

> proper adjustment for transfers would not have been offset by budget neutrality, and the Providers do not dispute or challenge any budget neutrality adjustment.
>
> 5. [Sub-]Question: "[I]t has come to the Board's attention that, in the September 1985 Final Rule, the Secretary asserted that the FY 1985 Federal rates were 'overstated' and cited to GAO [*i.e.*, the U.S. Government Accountability Organization] Report No. GAO/HRD-85-74 dated July 18, 1985 and entitled 'Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates.' In this regard, does the fact that, as part of this final rule, the Secretary exercised his discretion on how much to update the Federal rates, and did so taking into account this ***overstatement,*** suggest that the Providers' claim is now moot or that the real issue in dispute is whether the Secretary's exercise of discretion to make the FY 1986 adjustment was proper, valid, and/or sufficient?" (footnote omitted)
>
> Answer: No, the Secretary's setting of the FFY 1986 IPPS Federal rates does not suggest that the Providers' claim is moot, and the real issue in dispute is not whether the Secretary's FFY 1986 adjustment was proper, valid, and/or sufficient. In the FFY 1986 IPPS Final Rule, the Secretary set the FFY 1986 standardized amount at the same level as for FFY 1985. Had the Secretary properly adjusted for transfers when implementing IPPS in FFY 1984, the standardized amounts in both FFYs 1984 *and 1985* would have been higher. So when the Secretary maintained the FFY 1985 standardized amount for FFY 1986, the higher FFY 1985 standardized amount would have carried through as the same percentage higher amount for FFY 1986.[7]

The Board's third question asked whether the Providers' above answers impacted the Providers' position regarding the Board's substantive jurisdiction over the issue in these group appeals on administrative review over certain matters, particularly in light of the fact that 42 U.S.C. § 1395ww(d)(7) prohibits administrative review of certain matters. The Providers responded that it did not affect their position. Specifically, the Providers asserted that 42 U.S.C. § 1395ww(d)(7) "does not apply to these Group Appeals because, *inter alia*, the Providers are not seeking a retroactive adjustment to their 1984 or 1985 cost reporting periods or to any budget neutrality adjustment."[8]

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[7] *Id.* at 10-13 (footnote omitted and all emphasis in original except the underline emphasis added at end of the Answer to Sub-Questions 2, 4, and 5).
[8] *Id.* at 13.

The Board's fourth question asked whether there are any material issues in dispute that need resolution and/or development prior to the Board's consideration of EJR in these appeals. The Provider responded "no" and asserted that "all the issues in the Group Appeals concern issues of law or regulation that the Board lacks authority to decide" and that, "[t]o the extent that the ultimate calculation of damages requires determination of disputed facts, those facts only go to calculating relief, not to questions relevant to jurisdiction or authority, which are necessary to grant EJR."[9]

In the Providers' March 18, 2022 reply to the Medicare Contractor's response to the Board's RFI, the Providers make the following additional points:

1. The Providers recognized that the Medicare Contractors made arguments that the FFY 1985 budget neutrality adjustments could have been lower due to the fact that the Secretary did not adjust for using unaudited data in setting the initial standardized amounts. However, the Providers asserted that "the use of unaudited data is a wholly separate, unrelated issue from the Secretary's failure to account for transfers in setting the original standardized amounts. As such, any overstatement resulting from the use of unaudited data—an issue that is not currently under appeal—cannot be a defense or offset against the understatement caused by the appealed issue of the Secretary's failure to properly account for transfers."[10]

2. The Providers contended that "[the Medicare Contractors'] suggestion that the Secretary would have made a negative adjustment for FFY 1986 rates is counterfactual, wholly speculative, and directly contrary to the Secretary's explanation for his decision to carry the FFY 1985 rates forward to FFY 1986 without making a negative adjustment."[11]

3. The Providers agreed with the Medicare Contractors that "evaluation of any factual issues in the Providers' Expert Report [as attached to the August 10, 2020 EJR request] would be 'premature,' adding that a final quantification of the correction request by the Providers is a 'future question.'"[12] They further added that the Expert Report provided helpful background, context, and preliminary analysis of the issue in the Group Appeals.

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[9] *Id.*

[10] Providers' Consolidated Reply to the MAC's Response to the Board's October 27, 2021 Denials of EJR & Requests for Information, 8 (Mar. 18, 2022) ("Providers' Reply to the Medicare Contractor's Response to the Board's RFI").

[11] *Id.* In further support, the Providers' stated: "The Secretary explained that, even though the FFY 1985 standardized amounts were 'so overstated [based on issues unrelated to transfers] that a significant reduction could be justified,' he made an affirmative decision to 'maintain[] the FY 1986 Federal rates at the FY 1985 level.' 50 Fed. Reg. 35,646, 35,691. The Secretary expressly stated that any reduction in the rates would be 'undesirable.' *Id.* at 35,695. He explained that a reduction in rates— 'and a corresponding reduction of anticipated revenue for hospitals subject to the prospective payment system' — could cause ''disruptions and unintended consequences' that could 'adversely affect the industry and Medicare beneficiaries.' *Id.* at 35,708. The Secretary further explained his belief that maintaining the FFY 1985 rates was necessary for compliance with the statutory directive to ensure 'efficient and effective delivery of medically appropriate and necessary care of high quality.' *Id.* All of this reasoning would have applied equally even if the Secretary had properly accounted for transfers in setting the original standardized amounts two years before." *Id.* at 8-9.

[12] *Id.* at 10 (quoting the Medicare Contractor's Response to the Board's Denial of EJR & Requests for Information (Feb. 4, 2022)).

4. The Providers noted that they "have not received in response to their FOIA requests the data that the agency used to calculate the standardized amounts in the initial IPPS rulemaking in FFY 1984, which would likely allow the Providers *inter alia* to determine definitively the amount of their underpayments for the issue in the Group Appeals. The Expert Report, in part addresses what should happen if this data does not become available." Similarly, the Providers asserted that determining the amount of their underpayments will not ripen until a later stage such as "after EJR is granted and a court determines that the standardized amounts in the FFYs on appeal were understated." It is at that time that "the Providers expect to finalize their position regarding the amount of their underpayments and may need to amend and/or supplement the Expert Report and other filings based on additional facts or issues that might tend to decrease or increase the amount of the underpayments."[13]

Board Decision:

At the outset, the Board recognizes that the Providers' responses to the Board's RFI include objections to the Board's RFI. However, these objections were delinquent as they were not filed until over 3 months after the Board's RFI, as part of the Providers' February 5, 2022 response. Specifically, the Providers did not raise any objections: (1) after conferring with the Medicare Contractor and filing their November 16, 2021 response to the Board's request for a proposed briefing schedule; or (2) in their January 19, 2022 request for an extension to the deadline for their response to the RFI.

The 3-month delay in raising those objections deprived the Board of an opportunity to modify or clarify the RFI, as appropriate. Since the Providers filed their response a day after the Medicare Contractors filed their response to the Board's RFI, it also denied the opposing party of an opportunity to respond to those objections prior to filing their response to the Board's RFI. Accordingly, due to the untimeliness of those objections and the prejudice caused by the delay, the Board declines to entertain those objections.[14] Notwithstanding, the Board maintains its questions were appropriate.[15] The Board has an obligation to develop the record.[16] Similarly, the Board notes that consideration of expedited judicial review is not appropriate if there are

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[13] *Id.* at 10.

[14] Similarly, withholding objections for 3 months is not consistent with Board Rule 1.3 (Nov. 2021) which states:

> In accordance with the regulations, the Board expects the parties to an appeal *to communicate **early***, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. *The duty to communicate **early and** act in good faith* applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

(Emphasis added.)

[15] For example, in support of its position that the improper treatment of transfers resulted in underpayments, the Providers' EJR request cited *to the FFY 1984 budget neutrality adjustments principle* that the FFY 1984 aggregate payments were to be no greater than and no less than what would be paid if there were no IPPS. *See infra* note 41 and accompanying text (quoting the Providers' EJR Request at 3). As a result, the Board's inquiry relative to the FFY 1984 and 1985 budget neutrality adjustments was clearly relevant.

[16] *See, e.g.,* 42 C.F.R. § 405.1857.

material facts in dispute.[17] Accordingly, the Board's RFI was designed to further develop the record regarding both the highly complex nature of the Providers' dispute as it relates to whether the Board has jurisdiction to hear the Providers' dispute and whether EJR is appropriate (including whether there are material factual disputes).

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 5 CIRP groups because the initial 1983 standardized amounts,[18] set for the IPPS, are ***inextricably*** tied to the 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[19] and 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of those budget neutrality adjustments. The fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[20] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

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

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[21] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[22]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[23] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (i.e., inflated, standardized, grouped, and

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[17] *See, e.g.,* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (stating "After the Board began conducting hearings under section 1878 of the Act, it became evident that in cases where providers challenged an intermediary's determination based on objections to the validity of the law, regulations or CMS rulings, a hearing before the Board would not resolve the dispute. ***Because these cases did not raise factual issues*** and because, under section 1878(e) of the Act, the Board is bound by the law and regulations, the Board was obliged to decide these cases against the provider." (emphasis added)); 42 C.F.R. § 405.1842(d)(2)(ii) (2007) (specifying that an EJR request must "Allege and demonstrate that there are no factual issues in dispute" (emphasis added)); 42 C.F.R. § 405.1842(g)(2) (2007) (stating: "If there are factual or legal issues in dispute on an issue within the authority of the Board to decide, the Board will not make an expedited review determination on the particular issue but will proceed with a hearing.").

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

[19] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).

[20] *See infra* note 45 and accompanying text.

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

[22] *Id.*

[23] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).

adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[24] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[25] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

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

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[26] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—

[24] *Id.* (emphasis added).
[25] *Id*. at 39763-64.
[26] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[27]

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

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[28]

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

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion

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

> (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[29]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[30] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42

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

[30] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

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

U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,
>
> (VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,
>
> (IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

> (X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[31]

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

> (A) **UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—(i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized*

[31] (Emphasis added.)

amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

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

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

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for

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

Thus, while the Providers recognize that 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*,[32] they fail to recognize that it is not always a simple inflationary or market basket adjustment. In particular, the Providers fail to recognize the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable.

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

The Providers essentially are challenging the standardized amount used in the IPPS rates for FFY 2019 claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts.[33] More specifically, the Providers maintain that, "[d]uring the FFY 1984 IPPS rulemaking process [for the initial year of IPPS], which started in 1983, CMS used these *faulty 1981 statistics* to calculate the standardized amount for FFY 1984."[34] They further contend that "[t]he use of these faulty statistics led to the understatement of the standardized amount in the FFY 1984 IPPS Final Rule, which caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*."[35]

The published standardized amount for FFY 2019 reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3(A)) as well as other potential adjustments. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first 2 years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3(A). In

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[32] Providers' Response to the Board's RFI at 10-11 (Feb. 5, 2022).
[33] *See* Providers' EJR Request at 2-3 (Aug. 10, 2020).
[34] *Id.* at 4 (emphasis added).
[35] *Id.* (emphasis added).

addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase" as discussed below in Subsection C. Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year.

The Providers are, essentially, seeking to peel back the FFY 2019 amalgamated standardized amount *and, thus, reach back **35 years*** to increase the initial 1984 base rate that was used to set the initial 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the FFY 2019 amalgamated standardized amount (singular[36]) *as used in the FFY 2019 IPPS rates* back to the initial standardized amount***s*** (plural[37]) used in FFY 1984, and then carry/flow any change forward *to the FFY 2019, the year at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[38] More specifically, the FFY 2019 amalgamated standardized payment amount reflects the *fixed* FFY 1984 and 1985 budget neutrality adjustments (and not the initial FFY 1984 standardized amounts since the standardized amounts for both FFYs 1984 and 1985 were each adjusted for budget neutrality became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts because: (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2). Accordingly, the Board finds that the Providers challenge to the FFY 1984 standardized amounts are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.

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

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—

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[36] *See supra* note 3 and *infra notes* 68 and 69 and accompanying text.
[37] *See id.*
[38] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[39]

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

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

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[40] Indeed, the following excerpt from the Providers' EJR request references the budget neutrality adjustment made for FFY 1984 and suggests that the Providers recognize that the budget neutrality adjustment is *inextricably* tied to the final standardized amounts used for the FFY 1984 IPPS rates:

> As explained in more detail in the Providers' PPPs, these group appeals relate to actions taken by CMS when initially implementing IPPS. When doing so, *CMS stated in the FFY 1984 IPPS Interim Final Rule (at 39,755) that IPPS "payments may not be* ***greater than****,* ***nor*** ***less than****, the payments that would have been paid under the law previously in effect."* However, the IPPS

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

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

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

> payments for FFY 1984 were lower than the payments that Medicare would have made for FFY 1984 if the previous "reasonable cost" system had remained in place because, when initially implementing IPPS, CMS did not distinguish between "transfers" and "discharges" for purposes of calculating the IPPS "standardized amount" for FFY 1984. This caused IPPS underpayments for FFY 1984 that have continued for every subsequent FFY, up through and including the present, because CMS has used the FFY 1984 calculation of the standardized amount to calculate IPPS payments for all subsequent FFYs.
>
> ****
>
> In the FFY 1984 IPPS Final Rule (at 245-246 (emphasis added)), CMS assumed that the difference between "transfers" and "discharges" was not "significant":
>
> > With respect to the data used in computing prospective payment rates, we recognize that transfers were previously considered as discharges. Under the interim final rule, the transfer of a patient between two hospitals, each of which is subject to the prospective payment system, will not be considered a discharge for the transferring hospital. <u>This type of a transfer would have been a discharge under the reasonable cost reimbursement system</u>. However, no data were presented to indicate the actual effect, if any, that this difference between the definitions of discharge under the old and new payment system might have on the DRG rates.
> >
> > <u>With respect to the Federal rates, we would expect any discrepancy between the "old" and "new" definitions of discharge to have no significant effect on the rates</u>.
>
> This position is not supported by the evidence before CMS, which led the agency to pay transfers less than discharges under IPPS. Moreover, CMS did not explain the basis for this conclusion. Thus, the method that CMS used to create the initial IPPS payment rates for FFY 1984 **caused FFY 1984 IPPS payments to be less than what would have been paid under the previous "reasonable cost" system**, which means that IPPS hospitals were underpaid for FFY 1984 both on a per claim basis and in the aggregate.[41]

[41] Providers' EJR request at 3, 5 (footnote omitted, bold italics emphasis added, and underline emphasis in original).

As such, it is clear that the Providers are relying on the budget neutrality principle (the fact that the payments for FFY 1984 can be no greater than or less than what would have been paid in FFY 1984 had IPPS not been enacted and had hospitals continued to be paid on a reasonable cost basis) to support an adjustment to the FFY 1984 standardized amounts.[42] As a result, the potential increase to the base rate that the Providers are requesting is *inextricably* tied to the FFY 1984 and 1985 budget neutrality adjustments, and thus, is precluded from administrative and/or judicial review.[43]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the ***FFY 2019*** standardized rates are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

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

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

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment

[42] *See infra* notes 46 and 47 and accompanying text (discussing how the impact of transfers appears not to have been factored into the FFY 1984 budget neutrality adjustment).
[43] The Board notes that *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) did not review the substance of the Providers' challenge in the instant cases. Rather, it was focused on the validity of the predicate fact regulation located at 42 C.F.R. § 405.1885(a)(1) and the sole reference to 42 U.S.C. § 1395ww(d)(7) was simply to note that it did not address "predicate facts" as that term is used in § 405.1885(a)(1).

> system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[44]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[45] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the

[44] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[45] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[46]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.[47]

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

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[48]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates used for the first year of IPPS (*i.e.*, FFY 1984), as published on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the

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

[47] *See supra* notes 41 and 42 and accompanying text (discussing the fact that the Providers' EJR request cites to the budget FFY 1984 budget neutrality principle that total FFY 1984 IPPS payments may not be greater than or less than what would have been paid had IPPS not been enacted).

[48] *Id.* at 255.

reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

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

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

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[49]
>
> ****
>
> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years.

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

> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the overstatement of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite correction factor for FY 1986 that equals —7.5 percent.[50]

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

* * * * *

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY. Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[51] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the

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

[51] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board

budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985). Because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of those adjustments and the resulting *final* standardized amounts for those years were carried/flowed forward, the Board may not review the standardized amount used for FFY 2019 as it relates to the issue in these appeals, *i.e.*, the alleged inaccuracies in the standardized amounts used for FFY 1984 as carried/flowed forward for all years following FFY 1984 to FFY 2019.[52] In this regard, the Board notes that the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985 because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

C. Assuming arguendo the Board were to have substantive jurisdiction over the issue appealed in the 5 CIRP groups, it declines to address whether it believes a Board own-motion EJR would be appropriate.

In their March 18, 2022 reply to the Medicare Contractor's response to the Board's RFI, the Providers requested that, "if the Board were to find that it lacks jurisdiction over the Group Appeals, which the Providers believe would be incorrect, . . . [that[the Board also address whether (assuming *arguendo* jurisdiction) it believes it has the authority to address the issue in the Group Appeals."[53] As set forth below, the Board declines to address whether a Board own-motion EJR would be appropriate, assuming *arguendo* it were to have substantive jurisdiction over the issue appealed in the 5 CIRP groups.[54]

The Board has concerns that the Providers are oversimplifying the alleged nature of effect of the FFY 1984 standardized amounts issue ***on the FFY 2019 standardized amount***. Accordingly, the Board believes that the record needs further development as to the alleged nature of the Providers'

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jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[52] *See supra* note 51.

[53] Providers' Reply to Medicare Contractors' Response to the Board's RFI at 3 (Mar. 18, 2022).

[54] The Providers have no active or pending EJR requests filed before the Board and it would be inappropriate for the Board to do otherwise considering the Providers stated in their February 5, 2022 response to the Board's RFI (at 17) that "[t]he Providers *intend to* ***refile*** their EJR requests at the appropriate time, at which point the Board should immediately grant EJR for these Group Appeals." To date, the Providers have ***not*** refiled such an EJR request in any of the 5 CIRP groups.

alleged injury. The Providers' March 18, 2022 reply to the Medicare Contractor's response to the Board's RFI confirms the Board's apprehension, stating:

> The Expert Report provided helpful background, context, and preliminary analysis of the issue in the Group Appeals. Moreover, the Providers have not received in response to their FOIA requests the data that the agency used to calculate the standardized amounts in the initial IPPS rulemaking in FFY 1984, which would likely allow the Providers *inter alia* to determine definitively the amount of their underpayments for the issue in the Group Appeals. The Expert Report, in part, addresses what should happen if this data does not become available.
>
> . . . [T]he ultimate calculation of the necessary transfer adjustment factor and the determination of the amount of their underpayments will not ripen until a later stage (for example, after EJR is granted and a court determines that the standardized amounts in the FFYs on appeal were understated). **At such time, the Providers expect to finalize their position regarding the amount of their underpayments <u>and may need to amend and/or supplement the Expert Report and other filings</u>** based on additional facts or issues that might tend to decrease or increase the amount of the underpayments.[55]

The very fact that the Providers intend to further develop the record to establish the nature of the damages at issue ***via a designated "expert"*** (including the expert's ***planned*** future analysis of certain information which they have not yet received from FOIA as discussed below), confirms that the record may need further development and may not yet be ripe for consideration of EJR, whether by Board own-motion or by an EJR request filed by the Providers.

First, neither the Board nor the opposing party has had an opportunity to examine the Providers' designated expert[56] since the Providers only revealed the expert and expert report as an attachment to the Providers' August 10, 2020 EJR request.[57] Further, the Providers have not yet described in what area or field they are seeking to have the Board designate him as an "expert" pursuant to the process set forth in Board Rule 34 (2018):

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[55] Providers' Reply to Medicare Contractors' Response to the Board's RFI at 10 (Mar. 18, 2022) (emphasis added).
[56] 42 C.F.R. § 405.1859 states that "Witnesses at the hearing shall testify under oath or affirmation, unless excused by the Board for cause. The Board may examine the witnesses and shall allow the parties or their representatives to do so. Parties to the proceeding may also cross-examine witnesses."
[57] The Providers' Representative stated in the preliminary position papers filed in each of these CIRP groups that they "intend[ed] to submit an expert report that explains and quantifies these damages." Preliminary Position Paper ("PPP"), Case No. 19-0233GC, at 19 (May 22, 2020); PPP, Case No. 19-1628GC, at 19 (July 16, 2020); PPP, Case No. 19-1723GC, at 19 (July 10, 2020); PPP, Case No. 19-1735GC, at 19 (July 14, 2020); PPP, Case No. 19-1763GC, at 19 (July 8, 2020). However, the Providers' designation of that "expert" and the "expert" report were not filed until August 10, 2020 as Attachment D to the Providers' EJR Request.

Rule 34 Expert Witnesses

34.1 Expert Witness Defined

An expert witness is a person, who by virtue of his/her background, experience, or training has knowledge in a particular subject area outside the expertise of the decision maker sufficient that others may use their testimony to better understand or determine a fact at issue.

34.2 Expert Qualification

Expert qualification is appropriate for areas material to the dispute but in which the Board does not have expertise. The party presenting the expert must demonstrate that the expert is qualified in the designated area of expertise. The proposed expert is *subject to questioning by the opposing party and the Board as to his/her qualifications*. *The Board does not recognize as an expert any witness whose areas of expertise is legal interpretation of Medicare cost reimbursement issues because it falls within the Board's area of expertise*.

34.3 Expert Report

The expert must prepare a written report for submission to the opposing party's representative in accordance with Rule 28.[58]

Second, the Board has made no findings regarding the Providers' expert report, *particularly as it relates to* ***its application of Medicare cost reimbursement rules***. In this regard, the Board notes that, pursuant to Board Rule 34.2, it "does ***not*** recognize as an expert any witness whose areas of expertise is legal interpretation of Medicare cost reimbursement issues *because it falls* ***within the Board's area of expertise***."[59]

With regard to the "application of Medicare cost reimbursement rules" to the instant cases, the Board notes that significant time has passed since: (1) the base average cost per discharge for FFY 1984 was initially determined using 1981 cost data; (2) the initial FFY 1984 Federal IPPS rates were set as part of the interim final rule and final rule, published on September 1, 1983 and January 3, 1984 respectively, where those published rates reflected the budget neutrality adjustment mandated by 42 U.S.C. § 1395ww(e)(1)(B); and (3) the Federal IPPS rates for the next year, FFY 1985 were similarly set as part of the final rule published on August 31, 1984 where those published rates reflected the budget neutrality adjustment required under 42 U.S.C. §§ 1395ww(d)(3)(C) and 1395ww(e)(1)(B). However, neither these rulemakings nor the initial Federal rates exist in a vacuum and, therefore, the potential errors alleged by the Providers do not exist in a vacuum. During the intervening years of FFYs 1986 to 2018, Congress made significant alterations to the statutory provisions governing IPPS. Similarly, in the relevant statutory provisions

[58] (Italics and underline emphasis added.)
[59] (Emphasis added.)

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

Finally, the Board is aware of the Providers claim that they have been unable to calculate the amount in controversy or *actual* impact because they assert that they have a pending FOIA request(s) relating to the 1981 cost report data that was used to determine the base year amount.[60] However, the record does not contain a copy of that FOIA request(s) nor did the position papers filed in these cases include a status on that FOIA request(s) as required by Board Rule 25.2.2.[61] Indeed, the Providers' filings submitted on February 5, 2022 and March 18, 2022, in response to the Board RFI, reference the Providers' pending FOIA request(s) but do not provide any updates or other information on those FOIA request(s).[62] That said, the Board notes that the information

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[60] For example, in the final position paper filed in each of these five cases, the Providers give the following description of the impact the "expect to show" for FFY 1984 alone:

> Moreover, even in his original implementation of IPPS, the Secretary made multiple adjustments to the standardized amount of less than 0.2%, without any question whether the adjustments were sufficiently "significant" to implement. *See, e.g.*, Final Operating-Cost Rule, 49 Fed. Reg. at 326 (increasing standardized amount by 0.13% to account for costs previously billed under Medicare Part B and separately increasing standardized amount by 0.18% to account for additional FICA taxes). Again, Providers **expect to show** that the adjustment the Secretary should have made for transfers was many times higher than these adjustments.

Final Position Paper (Case Nos. 19-0233GC, 9-1628GC, 19-1763GC) at 14 n.2 (bold, underline emphasis added); Final Position Paper (Case Nos. 19-1723GC, 19-1735GC) at 14 n.3 (bold, underline emphasis added).

[61] Board Rule 25.2.2 (Nov. 2021) addresses "Unavailable and Omitted Documents" and states:

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

Here, it is unclear when the FOIA request was made, what efforts have been made between that submission and the position paper filing, and what the status of the FOIA request was at the time of the position paper filing.

[62] *See* Providers' Response to the Board's RFI at 10 (Feb. 5, 2022) (containing no reference to the pending FOIA request(s)); Providers' Reply to the Medicare Contractor's Response to the Board's RFI at 10 (Mar. 18, 2022) (containing only one reference to the FOIA simply stating: "Moreover, the Providers have not received in response to their FOIA requests the data that the agency used to calculate the standardized amounts in the initial IPPS rulemaking in FFY 1984, which would likely allow the Providers *inter alia* to determine definitively the amount of their underpayments for the issue in the Group Appeals.").

sought by the Providers appears to have been available to the public for roughly 25 years, as explained in the proposed rule issued on May 27, 1988:

> *B. Public Requests for Data*
>
> In order to respond promptly to public requests for data related to the prospective payment system, we have set up a process under which commenters can gain access to the raw data on an expedited basis. Generally, the data are available in computer tape format and are listed below with the cost of each tape. Anyone wishing to purchase data tapes should submit a written request along with a check to cover the cost of the tapes to the following address: HCFA Office of Statistics and Data Management, Bureau of Data Management and Strategy, Room l-F-2 Oak Meadows Building, 6325 Security Boulevard, Baltimore, MD 21207.
>
> ****
>
> 4. H180 **Extract, Cost Reporting Periods Ending January 1, 1981 through December 31, 1981**
>
> This file contains selected data items from cost reports. **These data were used in computing the initial Federal prospective payment rate**.
>
> Price: $530.00[63]

[63] 53 Fed. Reg. 19498, 19526 (May 27, 1988). Apparently, the Secretary made the data available in this manner due to demand, as previously the Secretary made this information available through FOIA as discuss in the following excerpt from the January 3, 1984 Final Rule:

> We agree hospitals should have access to the data used in connection with the development of the prospective payment system. We would like to point out that public access to disclosable information is provided under the Freedom of Information Act (5 U.S.C. 552). While we cannot guarantee that all requested information will be disclosed in the format desired by the requester, we will continue to respond promptly to all information requests and provide all available data to assist the hospital industry and other interested parties in the evaluation of the prospective payment system.
>
> In fact, much of the applicable data has already been made available to requesters. For example, the cost report file used as a basis for determining the budget neutrality adjustment factor and other factors had already been made available for public use before publication of the interim rule. This data, together with our descriptions of the budget neutrality determination published in section VIII of the Addendum to the interim rule, should allow our budget neutrality determination to be replicated. 49 Fed. Reg. at 251.

It is unclear to what extent any of this 1981 information continues to be available to the public at this late date and, if not, to what extent CMS is obligated to continue to make it available to the public at this late date. These questions could become relevant if the Board were to have jurisdiction and, following additional input from the parties, were to determine that material factual disputes exist, resulting in further record development by the parties.

Accordingly, the Board declines to opine, at this time, whether it would consider and grant an own-motion EJR in these cases *if, on appeal, the Administrator and/or a federal court were to find that the Board has substantive jurisdiction over the issue in these 5 CIRP group appeals*.[64] To do so at this juncture, without further input from the parties on the areas discussed above, would be premature.

* * * * *

In summary, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts; (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations) prohibit administrative and judicial review of those budget neutrality adjustments; and (3) thus, it does not have substantive jurisdiction over the issue in Case Nos. 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC. Accordingly, the Board hereby closes these CIRP group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

4/6/2023

X Clayton J. Nix

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

Attachment – Appendix A

cc: Byron Lamprecht, WPS Government Health Administrators
Cecile Huggins, Palmetto GBA
Dana Johnson, Palmetto GBA c/o National Government Services, Inc
Bill Tisdale, Novitas Solutions, Inc.

[64] Further, the Board notes that in Case Nos. 19-0233GC, 19-1735GC, and 19-1763GC, the Medicare Contractor filed Substantive Claim Challenges and that 42 C.F.R. § 405.1873(e)(1) precludes the Board from including any findings on substantive claim challenges in this jurisdictional dismissal decision. As such, for Case Nos. 19-0233GC, 19-1735GC, and 19-1763GC, the Board is precluded from discussing potential consideration of a Board own-motion EJR until such time that a reviewing body may later find that the Board has substantive jurisdiction.

APPENDIX A

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

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

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[65] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[66]

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

---

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

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

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

[66] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

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

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[67]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[68] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[69]

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

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

g. The subsequent amendments that Congress made in 1994[70] and 1997[71] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. This concern is highlighted by the Providers' admission that the Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS:

> Using this authority in the FY 1996 IPPS final rule, the Secretary offset an increase to payment rates for transfer cases through a

---

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

[68] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 18.

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

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

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

> reduction to the standardized amounts. *See* [60 Fed. Reg. 45778, 45854 (Sept. 1, 1995)] ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").[72]

To illustrate the complex nature of these issues, Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[73] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[74] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.
>
> In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law **to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more **nor** less than* we estimated would have been paid under prior legislation for the costs of the same

[72] Providers' Response to the Board's RFI at 7 (Feb. 5, 2022).
[73] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).
[74] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

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

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

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

	Percent
Forecasted market basket increase..	+4.27

Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[75]

****

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

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

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

[75] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

> Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.
>
> In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.
>
> We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**
>
> We received no comments on this issue.
>
> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[76] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates

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

(*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[77] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[78]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[79]

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

---

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

[78] 51 Fed. Reg. 16772, 16772 (May 6, 1986).

[79] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Seven Rivers Regional Medical Center (Prov. No. 10-0249)
FYE 09/30/2017
Case No. 21-0324

Dear Mr. Ravindran and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. ***Procedural History for Case No. 21-0324***

On June 17, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On December 1, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Errors)[1]
3. DSH – SSI Fraction Medicare Managed Care Part C Days[2]
4. DSH – SSI Fraction Dual Eligible Days[3]
5. DSH – Medicaid Eligible Days
6. DSH – Medicaid Fraction Medicare Managed Care Part C Days[4]
7. DSH – Medicaid Fraction Dual Eligible Days[5]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred issues 2 – 4 and 6 – 7 to Common Issue Related Party ("CIRP") groups on March 30,

[1] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1334GC.
[4] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1335GC.
[5] On March 30, 2021, this issue was transferred to PRRB Case No. 20-1336GC.

2021. As a result, the issues that remain pending are DSH – SSI Percentage (Provider Specific) and DSH – Medicaid Eligible Days issues.

On July 30, 2021, the Provider filed its preliminary position paper. On October 21, 2021, the Medicare Contractor filed a jurisdictional challenge asserting that Issue 1 should be dismissed as a prohibited duplicate appeal. The Provider did not file a response to this challenge within the 30-day period allotted under Board Rule 44.4.3.

On November 14, 2021, the Medicare Contractor filed a jurisdictional challenge asserting that Issue 5 should be dismissed due to the failure of the Provider to furnish a Medicaid eligible days listing or otherwise identify the days in dispute in its preliminary position paper.

On November 19, 2021, the Medicare Contractor filed its preliminary position paper.

On December 14, 2022, the Provider timely responded to the Medicare Contractor's motion to dismiss Issue 5 and asserted that they have not abandoned the issue. Significantly, the filing did *not* included a Medicaid eligible days listing or include any information identifying the actual days in dispute.

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

In their Individual Appeal Request, Provider summarizes its DSH – SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[6]

In the SSI percentage issue in CIRP group case 20-1332GC, which includes the Provider in this case, and the same fiscal year, the Providers assert that:

> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C.

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

> §1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[7]

The amount in controversy for Provider No. 10-0429 in Case No. 20-1332GC is $43,000, the same amount as issue #1 in the individual appeal.

On July 30, 2021, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Tennessee and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Tennessee and has learned that similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.

[7] Case No. 20-1332GC Issue Statement.

> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of those errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[8]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $43,216. This is the same amount (rounded) that is listed as the amount in controversy for this Provider as a participant in 20-1332GC.

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[9]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[10]

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[8] Provider's Preliminary Position Paper at 8-9 (Oct. 3, 2022).
[9] Jurisdictional Challenge #1 at 6-7 (Oct. 21, 2021).
[10] *Id*. at 4-6.

Issue 5 – DSH – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed. . .
>
> Within their preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[11]

Accordingly, the MAC requested that the Board dismiss the Medicaid eligible days issue.

Provider's Jurisdictional Response

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Provider did not file a response to this jurisdictional challenge. In this regard, Board Rule 44.4.3 states: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. *Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record*."[12]

Issue 5 – DSH – Medicaid Eligible Days

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[13] The Provider goes on to argue:

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.

[11] Jurisdictional Challenge #2 at 4 (Nov. 14, 2022).
[12] (Emphasis added.)
[13] Jurisdictional Response at 1 (Dec. 14, 2022).

> . . .
>
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment.[14]

The Provider goes on to assert that "[c]oncurrent with this letter . . . the Provider[is] sending to the MAC the listing of additional Medicaid eligible days" and that "[a] redacted version of this listing is being posted to the Board's portal." Accordingly, the Providers assert that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[15] However, the Board notes that the Provider did not file the promised redacted listing of Medicaid eligible days or even identify how many Medicaid eligible days are actually in dispute.

Finally, the Provider generically states that its operations were disrupted by the COVID-19 pandemic and that it continues to face challenges related to COVID-19. However, the Provider did not explain how those challenges affected the development of the Medicaid eligible days issue or its position paper filing.

Board Analysis and Decision:

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

A. DSH SSI Percentage (Provider Specific)

Based on the record before it (as explained in Board Rule 44.4.3 quoted above), the Board finds that it does not have jurisdiction over the DSH – SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-1332GC.

[14] *Id*. at 2.
[15] *Id*.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal basis for its DSH – SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH – SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH – SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH – SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH – SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-1332GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[20] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1332GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available*

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[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2.0 (Aug. 2018).
[20] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[21] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits in compliance with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

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

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

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

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

calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[22]16
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Accordingly, the Board finds that, *based on the record before it* (as explained in Board Rule 44.4.3 quoted above), Issue 1 in the instant appeal and the group issue from Group Case 20-1332GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules and 42 C.F.R. § 405.1853(b)(2)-(3).

2. Second Aspect of Issue 1

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

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

B. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

[22] Last accessed February 24, 2023.
[23] Emphasis added.

> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[24]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[25] The Provider later argued that there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[26]

Board Rule 7.3.1.2 (Nov. 2021) states:

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

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider's preliminary position paper promised that it would be sending the Medicaid eligible days listing under separate cover. But it failed to do so. Moreover, it did not state the precise number of Medicaid eligible days at issue but rather included the same "*estimated* impact"[27] calculation that was included with the appeal request. In its response to the

[24] Individual Appeal Request, Issue 5.
[25] Provider's Preliminary Position Paper at 8 (July 30, 2021).
[26] Jurisdictional Response at 1.
[27] (Emphasis added.)

Jurisdictional Challenge, the Provider is no belated arguing that, "at this time," there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor.

The Medicare Contractor asserts that that the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover and that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[28]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[29]

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

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

Similarly, with regard to position papers,[30] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[31] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[29] (Emphasis added).

[30] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[31] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[32]

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

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

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

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

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

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

[32] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. The Provider is misplaced in believing it could file its listing with the final position paper since the Rules and regulations cited above regarding position papers were in effect well before August 29, 2018. Moreover, the Provider appears to be well aware of the August 29, 2018 revised rules since it complied with those changes and filed it complete preliminary position paper.

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. *Based on the record before the Board*, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The Provider's belated generic assertion in its December 14, 2022 filing that "practical impediments are preventing [it] from obtaining the necessary support" due to "the eligibility matching being unavailable at this time due to a change in the State's matching vendor changes"34 is wholly inadequate because:

1. It failed to explain why it failed to include this information as part of its preliminary position paper in compliance with Board Rule 25.2.2 and fails to explain why this information was not available at the time it filed its preliminary position paper. The fact that "at this time" (i.e., as of December 14, 2022), it is not available does not mean that it was not available more than 3 years earlier when it filed its preliminary position paper in September 2019 when it promised one was being sent under separate cover. Indeed, it is unclear why the Provider has been unable to identify any actual Medicaid eligible days in dispute (whether that is one day or more).

2. Regardless, the statement fails to meet the requirements of Board Rule 25.2.2 since it did not describe its efforts to obtain the unavailable/missing documentation and when it would become available. Indeed, the response filed by the representative covered multiple providers across different states and it is unclear whether the generic references to "the State" was even relevant to this particular Provider and the state in which it is located.

In summary, without any days identified in the position paper filing (or in the record even at this late date), the Board must conclude that there are no actual days in dispute and that the amount in controversy is, in fact, $0.

Moreover, contrary to the Provider's assertion, the Provider has not attempted to cure this defect since the record still does not contain a listing of the Medicaid eligible days at issue.[34] Similarly, the Provider's reference to the COVID-19 pandemic has no relevance since the Provider's

[33] (Emphasis added).
[34] Note, the Board is *not* ruling that, had the provider done so, it would have accepted the listing at this late date. This situation is not before the Board and, as such, is not part of this ruling.

preliminary position paper was filed in 2019 well before the outbreak of the pandemic and the Board's issuance of Alert 19 and the Provider has failed to explain how its generic reference to the pandemic otherwise relates to its failure to comply with Board Rules and regulations and its development of the Medicaid eligible days issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[35] The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[36]

****

In summary, the Board hereby dismisses the DSH – SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue. As no issues remain pending, the Board hereby closes Case No. 21-0324 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

4/10/2023

X Clayton J. Nix

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

[35] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[36] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, in Case Nos. 13-3022, 13-3211, 14-2506, and 14-4313, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively) well in advance of the position paper filed in this case.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Re: ***Jurisdictional Decision***
Adventist Medical Center – Hanford (Prov. No. 05-0121, FYE 12/31/2008)
Case No. 14-0710

Dear Ms. Sze 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 and the Board's jurisdictional determination are set forth below.

Pertinent Facts

Adventist Medical Center – Hanford ("Provider") is a Medicare-certified acute care hospital located in Hanford, California. The Provider's servicing Medicare Administrative Contractor, Noridian Healthcare Solutions, LLC, and Federal Specialized Services, LLC, the Appeals Support Contractor, are together referred to herein as the "MAC."

The Notice of Program Reimbursement ("NPR") for this cost reporting period was issued on May 22, 2013. The Provider filed a hearing request with the Board on November 13, 2013. The Board acknowledged the request on December 12, 2013. The Provider appealed the following issues:

Issue 1: DSH – Medicaid Eligible Indigent Care Days[1]
Issue 2: DSH – Dual Eligible Medicare Advantage Part C Days - Medicaid Ratio[2]
Issue 3: DSH – Dual Eligible Part A Exhausted Benefits Days – Medicaid Ratio[3]
Issue 4: DSH – Medicaid Eligible Paid and Other Days[4]
Issue 5: DSH – Dual Eligible Medicare Advantage Part C Days – SSI Ratio[5]
Issue 6: DSH – SSI – Nursing Home Days[6]
Issue 7: DSH – SSI Accuracy[7]

[1] On February 18, 2013, the Provider transferred this issue to Case No. 14-2518GC.
[2] On February 18, 2013, the Provider transferred this issue to Case No. 14-2511GC.
[3] On February 18, 2013, the Provider transferred this issue to Case No. 14-2516GC.
[4] On February 18, 2013, the Provider transferred this issue to Case No. 14-2507GC.
[5] On July 25, 2014, the Provider transferred this issue to Case No. 13-3361GC.
[6] On July 25, 2014, the Provider transferred this issue to Case No. 13-3358GC.
[7] On November 15, 2013, the Provider transferred this issue to Case No. 13-3365GC.

Issue 8: Medicare IME Managed Care Unbilled Claims
Issue 9: Medicare Bad Debts, Crossover Unbilled[8]
Issue 10: GME – Prior Years' FTE Counts and Per Resident Amount
Issue 11: IME – Prior Years' FTE Counts and Intern/Resident to Bed Ratio
Issue 12: GME – Labor Room Days

After transferring Issues 1 through 7and withdrawing Issue 9, only issues 8, 10, 11, and 12 remain in the subject appeal.[9]

Medicare Contractor's Position

On January 28, 2021, the Medicare Contractor ("MAC") filed a jurisdictional challenge alleging that the Provider, in its Preliminary Position Paper filed on July 25, 2014, improperly expanded the scope of the specific items on appeal in both Issues 10 and 11. The Medicare Contractor requests that the Board dismiss: 1) the portions of Issue 10 regarding GME Base Year FTE Cap and GME Current Year Count ; and 2) the portions of Issue 11 regarding the IME Base Year FTE Cap and IME Current Year Count on the basis that the Provider did not appeal these specific items in its Hearing Request but has attempted to improperly add each of these aspects to Issues 10 and 11 through its Preliminary Position Paper filed July 25, 2014.

In its Model Form A – Individual Appeal Request, the Provider stated Issue 10 as:

> Issue #10: Whether the Intermediary's adjustment number 18, the exclusion of prior years' Resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved base year amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit base year amounts for a provider's approved residency educational program in order to establish an approved base year amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. The Intermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded to the hospitalin their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

In its Preliminary Position Paper, the Provider has described Issue 10 to include GME BaseYear FTE Cap (Exhibit C-6, page 5), as follows:

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[8] On October 22, 2020, the Provider withdrew this issue.
[9] *See* Medicare Contractor's Jurisdictional Challenge dated January 28, 2021.

> The Provider disputes the above disallowance of Graduate Medical Education reimbursement based on the fact that the base year residents were to be calculated per the Joint Scheduling Order for PRRB Case No 04-0100 (Exhibit P-43). The Intermediary was to determine the number of residents per the IRIS diskette for the computation of base year amount. The Provider is awaiting the determination of the resident count.
>
> Furthermore, in accordance with Section 422(a) of Public Law 108-173 a hospital may receive an increase in its FTE resident cap as a result of the agency's redistribution of unused resident positions. The hospital requested and received on October 27, 2005 additional DGME and IME slots pursuant to section 422 of Public Law 108-173 (Exhibit P-45).

Regarding Issue 11, the Provider stated the issue in its Hearing Request as:

> Issue #11. Whether the Intermediary's adjustment numbers 18, the inclusion of prior year Resident FTE for the Indirect Medical Education computation, should be adjusted based on any future settlements of the Provider Reimbursement Review Board decisions. The prior year settlement for fiscal year December 31, 2006 does not reflect resident counts for the provider's CMS approved expanded residency program in accordance with Section 422 of Public Lab 108-173 for additional IME FTE slots. Therefore the prior years' resident count has been understated. It is the provider's opinion that the Intermediary interpretation of the regulations is not within congressional intent to adequately reimburse providers for approved medical education.

In its Preliminary Position Paper, the Provider described Issue 11 to include the IME BaseYear FTE Cap, (Exhibit C-6, pages 10 and 11), as follows:

> As stated in the previous issue on GME reimbursement, the Provider initiated a new approved residency program on July 1, 2005 with Loma Linda University Medical Center. This new residency program preceded the merger with Selma Community Hospital which had a residency program for which the base year resident count was not reflective of the increase in the training programs through the last ten years. As the new program started on July 1, 2005, which is attached to Provider Number 05-0121 prior to the merger of Provider Number 05-0470, a new IME reimbursement settlement should have been incorporated in accordance with 42 C.F.R. Regulation Section 412.105(a)(ii) (Exhibit P-50) which provides for an exception for new programs for which the full time equivalent cap may be adjusted

> based on the period of years equal to the minimum accredited length of each new program. Section 412.105(f)(vii) states that in a new medical residencytraining program the full-time equivalent cap may be adjusted in accordance with the provisions of 42 C.F.R. Regulation 413.79(e)(1) through (e)(4) (Exhibit P-58).This section states that the resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program. Therefore, it would appear that the resident cap would be adjusted to the highest of any program years from fiscal years 2005 through 2008 and the resident count along with the prior years 2005 and 2006 should be stated at the actual amount as the cap has yet to be determined for these years.

The Medicare Contractor contends that Provider expanded Issues 10 and 11 to include new issues and that the Board lacks jurisdiction over the expanded issues because these expanded issues were not timely included in the subject appeal.

Provider's Position

The Provider contends that the MAC establishes no facts that would undermine the Board's jurisdiction under 42 U.S.C. section 1395oo(a) to consider this appeal. The MAC's Jurisdictional Challenge fails for the following reasons: (1) the MAC does not identify any defect that would undermine the Board's jurisdiction; (2) the Board Rules in place when the Provider submitted its Request for Hearing supports the identification of resident counts as sufficient detail; (3) the Graduate Medical Education ("GME") and Indirect Medical Education ("IME") Base Year FTE Caps are incorporated in and essential to adjudicate both Issue 10 (direct GME reimbursement) and Issue 11 (IME reimbursement) in its Request for Hearing; (4) the Board would consider the Base Year Cap issue in this consolidated appeal, which could then be applied to the fiscal year ending 2008 through a reopening; (5) the GME Current Year FTE count is incorporated in and essential to adjudicate Issue 10 and also incorporated via the GME Base Year Cap issue; (6) the MAC failed to demonstrate that it met and conferred prior to filing this motion in contravention of Board Rule 44.2, and (7) the Board found it had jurisdiction in a substantially similar jurisdictional challenge with the similar facts.[10]

The Provider asserts that it appropriately identified the GME Base Year Cap in its appeal of adjustment number 28[11]. The Provider's Model Form A – Individual Appeal Request states, in relevant part, as follows:

> Whether the Intermediary's adjustment number [2]8, the exclusion of prior years' Resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved **base year** amount

[10] *See* Case No. 18-1188 jurisdictional decision issued on April 3, 2020.
[11] The parties agree that the appropriate adjustment for Issue 10 was adjustment 28 not adjustment 18. *See* Provider's Opposition to Jurisdictional Challenge at 8.

> per resident, is in accordance with Regulation Section 413.86(e) which permitsthe Intermediary to re-audit **base year** amounts for a provider's approved residency educational program in order to establish an approved **base year** amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. […] However the Intermediary hasfailed to reimburse the provider for any Graduate Medical Education reimbursement.

Likewise, the Provider asserts that it appropriately identified Base Year Caps in its appeal of adjustment number 18 and 19 for issue 11. Specifically, the Provider's Model Form A – Individual Appeal Request states, as follows:

> Whether the Intermediary's adjustment numbers 18, **the inclusion of prior year Resident FTE** for the Indirect Medical Education computation, should be adjusted based on any future settlements of the Provider Reimbursement Review Board decisions. The prior year settlement for fiscal year December 31, 2006 does not reflect resident counts for the provider's CMS approved expanded residency program in accordance with Section 422 of Public Lab 108-173 for additional IME FTE slots. Therefore the prior years' resident count has been understated. It is the provider's opinion that the Intermediary interpretation of the regulations is not within congressional intent to adequately reimburse providers for approved medical education.

Board Decision

Relevant Statutes, Regulations and Board Rules

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

The subject appeal was filed with the Board in 2013 and the regulations effective at the time required the following:

> (b) *Contents of request for a Board hearing.* The provider's request for a Board hearing under paragraph (a) of this subsectionmust be submitted in writing to the Board, and the request must include . . .
>
> (2) An explanation . . . of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, including an account of…
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item . . . [and]

> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item…[12]

Board Rule 8 (March 1, 2013) elaborates on this regulation requiring explanation of issues, stating:

> 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…[13]

GME and IME Base Year Cap (portion of Issue 10 and Issue 11) in Case No. 14-0710

The Provider's Issue Statement #10 in Case No. 14-0710 reads:

> Whether the Intermediary's adjustment number 18, the exclusion of *prior years'* Resident full time equivalents (FTE's) for the Graduate Medical Education settlement ***and*** *the approved base year* amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit base year amounts for a provider's approved residency educational program in order to establish an approved *base year* amount per resident and to properly reimburse current ***and*** *prior year* Graduate Medical Education costs. The Intermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that *in accordance with Section 422 of Public Law 108-173* ***additional DGME and IME FTE slots were awarded*** to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.[14]

Issue Statement #11 reads:

> Whether the Intermediary's adjustment numbers 18, the inclusion of *prior year* Resident FTE for the Indirect Medical Education computation, should be adjusted ***based on any future settlements of the Provider Reimbursement Review Board decisions***. The prior year settlement for fiscal year December 31, 2006 *does not reflect resident*

[12] 42 C.F.R. § 405.1835(b) (2013).
[13] Provider Reimbursement Review Board Rules, Rule 8 (2013), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_03_01_2013.pdf
[14] (Emphasis added.)

> *counts for the provider's CMS approved expanded residency program in accordance with Section 422 of Public Lab 108-173 for additional IME FTE slots*. Therefore the prior years' resident count has been understated. It is the provider's opinion that the Intermediary interpretation of the regulations is not within congressional intent to adequately reimburse providers for approved medical education.

The Provider claims that its pending appeal relates to GME and IME base year caps. The Provider submitted its 2008 cost report without a Base Year Cap amount because the Base Year caps had not yet been established. The Provider appealed Adjustments Nos. 28, 18 and 19:

> Adjustment No. 28 states "To eliminate the current year FTE count (line 3.05)."
> Adjustment No. 18 states "To adjust total allowable FTE count for the penultimate year."
> Adjustment No. 19 states "To adjust the prior resident to bed ratio."

While these adjustments do not specifically adjust GME and IME Base Year Caps, the Board concludes that they are related and, therefore, finds that it has jurisdiction over the GME and IME Base Year Caps, current and prior year FTEs.

The Board **finds** jurisdiction over Issue 10 - GME – Prior Years' FTE Counts and Per Resident Amount and 11-IME – Prior Years' FTE Counts and Intern/Resident to Bed. The Medicare Contractor, through Audit Adjustment No. 28, has adjusted the cap for GME and, through Audit Adjustment No 18, has adjusted the cap for IME. The Board also notes that the issue statement for Issue 10 references the base year amount per resident and the issue statement for Issue 11 references the prior year FTEs and the intern to bed ratio that are impacted by the cap.

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

Board Members Participating:

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

FOR THE BOARD:

4/13/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Re: ***Jurisdictional Decision***
Adventist Medical Center – Hanford (Prov. No. 05-0121; FYE: 12/31/2009)
Case No.14-1690

Dear Ms. Sze 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 and the Board's jurisdictional determination are set forth below.

Pertinent Facts

Adventist Medical Center – Hanford ("Provider") is a Medicare-certified acute care hospital located in Hanford, California. The Provider's servicing Medicare Administrative Contractor, Noridian Healthcare Solutions, LLC, and Federal Specialized Services, LLC, the Appeals Support Contractor, are together referred to herein as the "MAC."

The Notice of Program Reimbursement ("NPR") for this cost reporting period was issued on July 17, 2013. The Provider filed a hearing request with the Board on January 8, 2014. The Board acknowledged the request on January 10, 2014. The Provider appealed the following issues:

Issue 1: DSH – Medicaid Eligible Indigent Care Days[1]
Issue 2: DSH – Dual Eligible Medicare Advantage Pt C Days - Medicaid Ratio[2]
Issue 3: DSH – Dual Eligible Part A Exhausted Benefits Days – Medicaid Ratio[3]
Issue 4: DSH – Medicaid Eligible Paid and Other Days[4]
Issue 5: Medicare IME Managed Care unbilled claims
Issue 6: Medicare Bad Debts, Indigent Accounts[5]
Issue 7: GME- Current and Prior Years' FTE Counts and Per Resident Amount
Issue 8: IME- Current Year FTE Counts
Issue 9: DSH- Labor Room Days

[1] On July 25, 2014, the Provider transferred this issue to case no. 14-3841GC.
[2] On July 25, 2014, the Provider transferred this issue to case no. 14-3842GC.
[3] On July 25, 2014, the Provider transferred this issue to case no. 14-3843GC.
[4] On July 25, 2014, the Provider transferred this issue to case no. 14-3844GC.
[5] On October 22, 2020, the Provider withdrew this issue.

After the transfer of Issues 1 through 4 and the withdrawal of Issue 6, only Issues 5, 7, 8, and 9 remain in the subject appeal.

Medicare Contractor's Position

On January 21, 2021, the Medicare Contractor ("MAC") filed a jurisdictional challenge alleging that the Provider, in its Preliminary Position Paper filed on August 18, 2014, improperly expanded the scope of the specific items on appeal in both Issues 7 and 8. The Medicare Contractor requests that the Board dismiss: 1) the portion of Issue 7 related to GME Base Year FTE Cap; and 2) the portions of Issue 8 related to IME Base Year Resident-to-Bed Ratio on the basis that the Provider did not appeal these specific items in its hearing request but has attempted to improperly add these new items to Issues 7 and 8 through its Preliminary Position Paper dated August 11, 2014.

In its Model Form A – Individual Appeal Request (January 8, 2014), the Provider stated Issue 7 as:

> Issue #7: Whether the Intermediary's adjustment number 19, the exclusion of current and prior years' resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved base year amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit base year amounts for a provider's approved residency educational program in order to establish an approved base year amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. The Intermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

In its Preliminary Position Paper, the Provider described Issue 7 to include GME BaseYear FTE Cap (Exhibit C-6, page 5), as follows:

> The Provider disputes the above disallowance of Graduate Medical Education reimbursement based on the fact that the base year residents were to be calculated per the Joint Scheduling Order for PRRB Case No 04-0100 (Exhibit P-43). The Intermediary was to determine the number of residents per the IRIS diskette for the computation of base

> year amount. The Provider is awaiting the determination of the resident count.
>
> Furthermore, in accordance with Section 422(a) of Public Law 108-173 a hospital may receive an increase in its FTE resident cap as a result of the agency's redistribution of unused resident positions… The hospital requested and received on October 27, 2005 additional DGME and IME slots pursuant to section 422 of Public Law 108-173 (Exhibit P-45).

The Provider further described the issue to include the GME Base Year FTE Cap within the Provider's Preliminary Position Paper on pages 54 and 55 (Exhibit C-6, pages 7 and 8), as follows:

> Furthermore, since the new Loma Linda residency program started prior to the merger with Selma Community Hospital's residency program, a new program should be established with fiscal period July 1, 2005 to December 31, 2005 as a cost based year and the first full cost reporting year January 1, 2006 to December31, 2006 as a base year rate to determine the Per Resident Amount (PRA). Since the medical education program is a new program 42 C.F.R. Regulation Section 413.79(e) (Exhibit P-19) will determine the base year resident cap which is the highest resident amount within the third year of the program's existence adjusted based on the product of the highest third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length forthe type of the program. The base year residents should be used to complete CMS2552-96 Part IV lines 3.02, 3.05 and 3.07 with prior year resident amounts from fiscal years 2006 and 2007 to be included on lines 3.19 and 3.20. Therefore, the Intermediary adjustments are incorrect, as a new PRA should have been established in fiscal year 2006 with the appropriate base year rate in 2006 adjusted for the time period and inflated based on an annual basis and the residentcap based on the 2008 resident count adjusted for the highest number of resident [sic] by the years of residency to complete their accredited program.

The Provider also further described the issue to include the GME Current Year FTE Count within the Conclusion of the Provider's Preliminary Position Paper on page 56 (Exhibit C-6, page 9), as follows:

> … the Provider petitions the Provider Reimbursement Review Board to require the Intermediary to establish a per resident amount, current year and prior year residentcounts to keep with the interpretation of new residency training programs as per 42 C.F.R. Section 413.44 and the spirit of Section 422 of Public Law 108-173 toadequately reimburse the provider their increased resident training costs.

Regarding Issue 8, the Provider stated the issue in its Hearing Request as:

> Issue #8. Whether the Intermediary's adjustment number 11, the exclusion of current year resident FTE's for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider has incurred the costs for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulations Sections 412.105 and 413.79.

In its Preliminary Position Paper, the Provider described Issue 8 to include the IME BaseYear FTE Cap, (Exhibit C-6, pages 11 and 12), as follows:

> As stated in the previous issue on GME reimbursement, the Provider initiated a new approved residency program on July 1, 2005 with Loma Linda University Medical Center. This new residency program preceded the merger with Selma Community Hospital which had a residency program for which the base year resident count was not reflective of the increase in the training programs through the last ten years. As the new program started on July 1, 2005, which is attached to Provider Number 05-0121 prior to the merger of Provider Number 05-0470, a new IME reimbursement settlement should have been incorporated in accordance with 42 C.F.R. Regulation Section 412.105(a)(ii) (Exhibit P-50) which provides for an exception for new programs for which the full time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program. Section 412.105(f)(vii) states that in a new medical residencytraining program the full-time equivalent cap may be adjusted in accordance with the provisions of 42 C.F.R. Regulation 413.79(e)(1) through (e)(4) (Exhibit P-19).This section states that the resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program. Therefore, it would appear that the resident cap would be adjusted to the highest of any program years from fiscal years 2005 through 2008 and the resident count along with the prior years 2007 and 2008 should be stated at the actual amount as the cap has yet to be determined for these years.

The Medicare Contractor contends that the Provider expanded Issues 7 and 8 to include new issues and that the Board lacks jurisdiction over the expanded issues because the expanded issues were not timely included in the subject appeal.

Provider's Position

The Provider contends that the MAC establishes no facts that would undermine the Board's jurisdiction under 42 U.S.C. section 1395oo(a) to consider this appeal. The MAC's Jurisdictional Challenge fails for the following reasons: (1) the MAC does not identify any defect that would undermine the Board's jurisdiction; (2) the Board Rules in place when the Provider submitted its Request for Hearing supports the identification of resident counts as sufficient detail; (3) the Graduate Medical Education ("GME") and Indirect Medical Education ("IME") Base Year FTE Caps are incorporated in and essential to adjudicate both Issue 7 (direct GME reimbursement) and Issue 8 (IME reimbursement) in its Request for Hearing; (4) the Board would consider the Base Year Cap issue in this consolidated appeal, which could then be applied to the fiscal year ending 2009 through a reopening; (5) the Prior Year IME FTE count, the Penultimate Year IME FTE count, and the Prior Year Resident-to-Bed Ratio are incorporated in Issue 8 via the IME Base Year Cap issue; (6) the MAC failed to demonstrate that it met and conferred prior to filing this motion, in contravention of Board Rule 44.2, and (7) the Board found it had jurisdiction in a substantially similar jurisdictional challenge with the similar facts.[6]

The Provider asserts that it appropriately identified the GME Base Year Cap in its appeal of adjustment number 19.

Provider's Model Form A – Individual Appeal Request states, in relevant part, as follows:

> Whether the Intermediary's adjustment number 19, the exclusion of current and prior years' Resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved **base year** amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit **base year** amounts for a provider's approved residency educational program in order to establish an approved **base year** amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. […] However the Intermediary hasfailed to reimburse the provider for any Graduate Medical Education reimbursement.

Likewise, the Provider appropriately identified Base Year Caps in its appeal of adjustment number 11 for issue 8. Specifically, the Provider's Model Form A – Individual Appeal Request states, as follows:

> Whether the Intermediary's adjustment number 11, the **exclusion of current year resident FTE's** for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the cost for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulation Sections **412.105** and **413.79.**

[6] See Case No. 18-1188 jurisdictional decision issued on April 3, 2020.

Board Decision

Relevant Statutes, Regulations and Board Rules

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

The subject appeal was filed with the Board in 2014 and the regulations effective at the time required the following:

> (b) *Contents of request for a Board hearing.* The provider's request for a Board hearing under paragraph (a) of this subsectionmust be submitted in writing to the Board, and the request must include . . .
>
> (i) An explanation . . . of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, includingan account of…
>
> (ii) Why the provider believes Medicare payment is incorrect for each disputed item . . . [and]
>
> (iii)How and why the provider believes Medicare payment must be determined differently for each disputed item…[7]

Board Rule 8 (March 1, 2013) elaborates on this regulation requiring explanation of issues, stating:

> 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…[8]

GME and IME Base Year Cap (portion of Issue 7 and Issue 8) in Case No. 14-1690

The Provider's Issue Statement #7 in Case No. 14-1690 reads:

> Whether the Intermediary's adjustment number 19, the exclusion of *current and prior years'* resident full time equivalents (FTE's) for the Graduate Medical Education settlement ***and*** the approved *base year* amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary *to re-audit* ***base year*** *amounts* for a provider's approved residency educational program in

[7] 42 C.F.R. § 405.1835(b) (2013).
[8] Provider Reimbursement Review Board Rules, Rule 8 (2013), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_03_01_2013.pdf

> order to establish an approved ***base year*** amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. The Intermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that *in accordance with Section 422 of Public Law 108-173* additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

Issue Statement #8 reads:

> Whether the Intermediary's adjustment number 11, the exclusion of current year resident FTE's for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider has incurred the costs for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulations Sections 412.105 and 413.79.

The Provider claims that its pending appeal relates to GME and IME base year caps. The Provider submitted its 2009 cost report without a Base Year Cap amount because the Base Year caps had not yet been established. The Provider appealed Adjustments Nos. 19 and 11.

> Adjustment No. 19 states "removal of the GME Per Resident Amount (PRA)."
>
> Adjustment No. 11 states "removal of allopathic and osteopathic programs."

While these adjustments do not specifically adjust GME and IME Base Year Caps, the Board concludes that they are related and, therefore, finds that it has jurisdiction over the GME and IME Base Year Caps, current and prior year FTEs. The Board **finds** jurisdiction over Issue 7 - GME – Prior Years' FTE Counts and Per Resident Amount and 8-IME – Current Year and Prior Year FTE Counts. The Medicare Contractor, through adjustment number 19 and 11, has adjusted the cap for GME and, through adjustment 17 and 18, has adjusted the cap for IME.

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

Board Members Participating:

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

FOR THE BOARD:

4/13/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, FSS

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Re: ***Jurisdictional Decision***
Adventist Medical Center – Hanford (Prov. No. 05-0121; FYE 12/31/2010)
Case No. 15-2015

Dear Ms. Sze 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 and the Board's jurisdictional determination are set forth below.

Pertinent Facts

Adventist Medical Center – Hanford ("Provider") is a Medicare-certified acute care hospital located in Hanford, California. The Provider's servicing Medicare Administrative Contractor, Noridian Healthcare Solutions, LLC, and Federal Specialized Services, LLC, the Appeals Support Contractor, are together referred to herein as the "MAC."

The Notice of Program Reimbursement ("NPR") for this cost reporting period was issued on November 4, 2014. The Provider filed a hearing request with the Board on March 27, 2015. The Board acknowledged the request on April 7, 2015. The Provider appealed the following issues:

Issue 1: DSH – Medicaid Eligible Indigent Care Days[1]
Issue 2: DSH – Dual Eligible Medicare Advantage Part C Days - Medicaid Ratio[2]
Issue 3: DSH – Dual Eligible Part A Exhausted Benefits Days – Medicaid Ratio[3]
Issue 4: DSH – Medicaid Eligible Paid and Other Days[4]
Issue 5: Medicare Bad Debts, Indigent Accounts[5]
Issue 6: GME- Current and Prior Years' FTE Counts and Per Resident Amount
Issue 7: IME- Current Year and Prior Year FTE Counts

[1] On August 5, 2015, the Provider transferred this issue to Case No. 15-3115GC.
[2] On August 5, 2015, the Provider transferred this issue to Case No. 15-3117GC.
[3] On October 22, 2015, the Provider withdrew this issue.
[4] On August 5, 2015, the Provider transferred this issue to Case No. 15-3113GC.
[5] On October 22, 2020, the Provider withdrew this issue.

After the transfer of Issues 1, 2, and 4 and the withdrawal of Issues 3 and 5, only Issues 6 and 7 remain in the subject appeal.[6]

Medicare Contractor's Position

On February 1, 2021, the Medicare Contractor ("MAC") filed a jurisdictional challenge alleging that the Provider, in its Preliminary Position Paper filed on November 11, 2015, improperly expanded the scope of the specific items on appeal in both Issues 6 and 7. The Medicare Contractor requests that the Board dismiss: 1) the portions of Issue 6 regarding GME Base Year FTE Cap; and 2) the portions of Issue 7 regarding the IME Base Year FTE Cap on the basis that the Provider did not appeal these specific items in its Hearing Request but has attempted to improperly add each of these aspects to Issues 6 and 7 through its Preliminary Position Paper filed November 11, 2015.

In its Model Form A – Individual Appeal Request, the Provider stated Issue 6 as:

> Issue #6: Whether the Intermediary's adjustment numbers 25, 26, 27 and 28, the exclusion of current and prior years' resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved base year amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit base year amounts for a provider's approved residency educational program in order to establish an approved base year amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. TheIntermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

In its Preliminary Position Paper, the Provider described Issue 6 to include GME BaseYear FTE Cap (Exhibit C-6, page 5), as follows:

> The Provider disputes the above disallowance of Graduate Medical Education reimbursement based on the fact that the base year residents were to be calculated per the Joint Scheduling Order for PRRB Case No 04-0100 (Exhibit P-43). The Intermediary was to determine the number of residents per the IRIS diskette for the computation of base year amount. The Provider is awaiting the determination of the resident count.

[6] *See* Medicare Contractor's Jurisdictional Challenge dated February 1, 2021.

> Furthermore, in accordance with Section 422(a) of Public Law 108-173 a hospital may receive an increase in its FTE resident cap as a result of the agency's redistribution of unused resident positions… The hospital requested and received on October 27, 2005 additional DGME and IME slots pursuant to section 422 of Public Law 108-173 (Exhibit P-45).

Regarding Issue 7, the Provider stated the issue in its Hearing Request as:

> Issue #7. Whether the Intermediary's adjustment number 15, the reduction of current year and prior year resident FTE's for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the costs for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulations Sections 412.105 and 413.79.

In its Preliminary Position Paper, the Provider described Issue 7 to include the IME BaseYear FTE Cap, (Exhibit C-6, pages 12 and 13), as follows:

> As stated in the previous issue on GME reimbursement, the Provider initiated a new approved residency program on July 1, 2005 with Loma Linda University Medical Center. This new residency program preceded the merger with Selma Community Hospital which had a residency program for which the base year resident count was not reflective of the increase in the training programs through the last ten years. As the new program started on July 1, 2005, which is attached to Provider Number 05-0121 prior to the merger of Provider Number 05-0470, a new IME reimbursement settlement should have been incorporated in accordance with 42 C.F.R. Regulation Section 412.105(a)(ii) (Exhibit P-50) which provides for an exception for new programs for which the full time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program. Section 412.105(f)(vii) states that in a new medical residencytraining program the full-time equivalent cap may be adjusted in accordance with the provisions of 42 C.F.R. Regulation 413.79(e)(1) through (e)(4) (Exhibit P-19).This section states that the resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program. Therefore, it would appear that the resident cap would be adjusted to the highest of any program years from fiscal years 2005 through 2008 and the resident count along with the prior years 2008 and 2009 should be stated at the actual amount as the cap has yet to be determined for these years.

The Medicare Contractor contends that the Provider expanded Issues 6 and 7 to include new issues and that the Board lacks jurisdiction over the expanded issues because the expanded issues were not timely included in the subject appeal.

Provider's Position

The Provider contends that the MAC establishes no facts that would undermine the Board's jurisdiction under 42 U.S.C. section 1395oo(a) to consider this appeal. The MAC's Jurisdictional Challenge fails for the following reasons: (1) the MAC does not identify any defect that would undermine the Board's jurisdiction; (2) the Board Rules in place when the Provider submitted its Request for Hearing supports the identification of resident counts as sufficient detail; (3) the Graduate Medical Education ("GME") and Indirect Medical Education ("IME") Base Year FTE Caps are incorporated in and essential to adjudicate both Issue 6 (direct GME reimbursement) and Issue 7 (IME reimbursement) in its Request for Hearing; (4) the Board would consider the Base Year Cap issue in this consolidated appeal, which could then be applied to the fiscal year ending 2010 through a reopening; (5) the MAC failed to demonstrate that it met and conferred prior to filing this motion, in contravention of Board Rule 44.2, and (6) the Board found it had jurisdiction in a substantially similar jurisdictional challenge with the similar facts.[7]

The Provider asserts that it appropriately identified the GME Base Year Cap in its appeal of adjustment number 25, 26, 27 and 28. The Provider's Model Form A – Individual Appeal Request states, in relevant part, as follows:

> Whether the Intermediary's adjustment numbers 25, 26, 27, and 28, the exclusion of current and prior years' Resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved **base year** amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit **base year** amounts for a provider's approved residency educational program in order to establish an approved **base year** amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. […]

Likewise, the Provider asserts that it appropriately identified Base Year Caps in its appeal of adjustment number 15 for issue 7. Specifically, the Provider's Model Form A – Individual Appeal Request states, as follows:

> Whether the Intermediary's adjustment number 15, the **reduction of current year and prior year resident FTE's** for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the cost for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulation Sections 412.105 and 413.79.

[7] See Case No. 18-1188 jurisdictional decision issued on April 3, 2020.

Board Decision

Relevant Statutes, Regulations and Board Rules

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

The subject appeal was filed with the Board in 2015 and the regulations effective at the time required the following:

> (b) *Contents of request for a Board hearing.* The provider's request for a Board hearing under paragraph (a) of this subsectionmust be submitted in writing to the Board, and the request must include . . .
>
> (i) An explanation . . . of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, includingan account of…
>
> (ii) Why the provider believes Medicare payment is incorrect foreach disputed item . . . [and]
>
> (iii)How and why the provider believes Medicare payment must be determined differently for each disputed item…[8]

Board Rule 8 (July 1, 2015) elaborates on this regulation requiring explanation of issues, stating:

> 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…[9]

GME and IME Base Year Cap (portion of Issue 6 and Issue 7) in Case No. 15-2015

The Provider's Issue Statement #6 in Case No. 15-2015 reads:

> Whether the Intermediary's adjustment numbers 25, 26, 27 and 28, the exclusion of *current and prior years'* resident full time equivalents (FTE's) for the Graduate Medical Education settlement ***and*** the approved *base year* amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit ***base year*** amounts for a provider's approved residency educational program in order to establish an approved ***base year***

[8] 42 C.F.R. § 405.1835(b) (2013).
[9] Provider Reimbursement Review Board Rules, Rule 8 (2015), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_07_01_2015.pdf

> amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. TheIntermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that *in accordance with Section 422 of Public Law 108-173* additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.[10]

Issue Statement #7 reads:

> Whether the Intermediary's adjustment number 15, the reduction of current year and prior year resident FTE's for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the costs for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulations Sections 412.105 and 413.79.[11]

The Provider claims that its pending appeal relates to GME and IME base year caps. The Provider submitted its 2010 cost report without a Base Year Cap amount because the Base Year caps had not yet been established. The Provider appealed Adjustments Nos. 15, 25, 26, 27 and 28:

> Adjustment No. 15 states "to adjust IME FTE count and rolling average per review."
>
> Adjustment No. 25 states "to adjust the Primary Care Physicians and OB/GYN PRA amount per review."
>
> Adjustment No. 26 states "to adjust GME FTE count for programs which meet the criteria for an add on the cap for new programs per review."
>
> Adjustment No. 27 states "to adjust GME FTE count and rolling average per review."
>
> Adjustment No. 28 states "to adjust the Locality-adjusted national average PRA amount per review."

[10] (Emphasis added.)
[11] (Emphasis added.)

While these adjustments do not specifically adjust GME and IME Base Year Caps, the Board concludes that they are related and, therefore, finds that it has jurisdiction over the GME and IME Base Year Caps, current and prior year FTEs.

The Board **finds** jurisdiction over Issue 6 - GME – Current and Prior Years' FTE Counts and Per Resident Amount and 7 -IME – Current Year and Prior Year FTE Counts. The Medicare Contractor, through adjustment number 25, 26, 27, and 28, has adjusted the cap for GME and, through adjustment 15, has adjusted the cap for IME.

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

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

FOR THE BOARD:

4/13/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Re: ***Jurisdictional Decision***
Adventist Medical Center – Hanford (Prov. No. 05-0121; FYE 12/31/2011)
Case No. 16-1274

Dear Ms. Sze 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 and the Board's jurisdictional determination are set forth below.

Pertinent Facts

Adventist Medical Center – Hanford ("Provider") is a Medicare-certified acute care hospital located in Hanford, California. The Provider's servicing Medicare Administrative Contractor, Noridian Healthcare Solutions, LLC, and Federal Specialized Services, LLC, the Appeals Support Contractor, are together referred to herein as the "MAC."

The Notice of Program Reimbursement ("NPR") for this cost reporting period was issued on February 11, 2016. The Provider filed a hearing request with the Board on March 14, 2016. The Board acknowledged the request on May 23, 2016. The Provider appealed the following issues:

Issue 1: Bad Debts, Reasonable Collections Efforts
Issue 2: Bad Debts, Indigent Accounts
Issue 3: GME- Current and Prior Years' FTE Counts and Per Resident Amount
Issue 4: IME- Current Year and Prior Year FTE Counts

All issues remain pending in this appeal.

Medicare Contractor's Position

On November 13, 2020, the Medicare Contractor ("MAC") filed a jurisdictional challenge alleging that the Provider, in its Preliminary Position Paper filed on November 21, 2016, improperly expanded the scope of the specific items on appeal in both Issues 3 and 4. The Medicare Contractor requests that the Board dismiss the GME Base Year FTE Cap portion of Issue 3 and the IME Base Year FTE Cap portion of Issue 4 on the basis that the Provider did not

include either of these within it hearing request but has attempted to add each of these aspects to Issues 3 and 4 through its Preliminary Position Paper filed November 21, 2016.

In its Model Form A – Individual Appeal Request (March 23, 2016), the Provider stated Issue 3 as:

> Issue #3: Whether the Intermediary's adjustment numbers 35, 36, 37, 38, 39 and 40, the exclusion of current and prior years' resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved base year amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit base year amounts for a provider's approved residency educational program in order to establish an approved base year amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. TheIntermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

In its Preliminary Position Paper, the Provider described Issue 3 to include GME BaseYear FTE Cap (Exhibit C-6, page 5), as follows:

> The Provider disputes the above disallowance of Graduate Medical Education reimbursement based on the fact that the base year residents were to be calculated per the Joint Scheduling Order for PRRB Case No 04-0100 (Exhibit P-21). The Intermediary was to determine the number of residents per the IRIS diskette for the computation of base year amount. The Provider is awaiting the determination of the resident count.
>
> Furthermore, in accordance with Section 422(a) of Public Law 108-173 a hospital may receive an increase in its FTE resident cap as a result of the agency's redistribution of unused resident positions… The hospital requested and received on October 27, 2005 additional DGME and IME slots pursuant to section 422 of Public Law 108-173 (Exhibit P-23).

The Provider further described the issue to include the GME Base Year FTE Cap within the Provider's Preliminary Position Paper (Exhibit C-6, pages 8), as follows:

> Furthermore, since the new Loma Linda residency program started prior to the merger with Selma Community Hospital's residency program, a new program should be established with fiscal period July 1, 2005 to December 31, 2005 as a cost based year and the first full cost reporting year January 1, 2006 to December31, 2006 as a base year rate to determine the Per Resident Amount (PRA). Since the medical education program is a new program 42 C.F.R. Regulation Section 413.79(e) (Exhibit P-27) will determine the base year resident cap which is the highest resident amount within the third year of the program's existence adjusted based on the product of the highest third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program based on the minimum accredited length forthe type of the program. The base year residents should be used to complete CMS2552-10 Worksheet Part E-4 lines 2, 6, and 8 with prior year resident amounts from fiscal years 2009 and 2010 to be included on lines 12 and 13. Therefore, the Intermediary adjustments are incorrect, as a new PRA should have been established in fiscal year 2006 with the appropriate base year rate in 2006 adjusted for the time period and inflated based on an annual basis and the residentcap based on the 2008 resident count adjusted for the highest number of resident [sic] by the years of residency to complete their accredited program.

The Provider also further described the issue to include the GME Current Year FTE Count within the Conclusion of the Provider's Preliminary Position Paper (Exhibit C-6,page 10), as follows:

> … the Provider petitions the Provider Reimbursement Review Board to require the Intermediary to establish a per resident amount, current year and prior year residentcounts to keep with the interpretation of new residency training programs as per 42 C.F.R. Section 413.44 and the spirit of Section 422 of Public [Law] 108-173 and Section 5503 of Public [sic] 111-148 toadequately reimburse the provider their increased resident training costs.

Regarding Issue 4, the Provider stated the issue in its Hearing Request as:

> Issue #4. Whether the Intermediary's adjustment number 17 and 18, the reduction of prior year resident FTE counts for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the costs for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulations Sections 412.105 and 413.79.

In its Preliminary Position Paper, the Provider described Issue 4 to include the IME BaseYear FTE Cap, (Exhibit C-6, pages 12 and 13), as follows:

> As stated in the previous issue on GME reimbursement, the Provider initiated a new approved residency program on July 1, 2005 with Loma Linda University Medical Center. This new residency program preceded the merger with Selma Community Hospital which had a residency program for which the base year resident count was not reflective of the increase in the training programs through the last ten years. As the new program started on July 1, 2005, which is attached to Provider Number 05-0121 prior to the merger of Provider Number 05-0470, a new IME reimbursement settlement should have been incorporated in accordance with 42 C.F.R. Regulation Section 412.105(a)(ii) (Exhibit P-32) which provides for an exception for new programs for which the full-time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program. Section 412.105(f)(vii) states that in a new medical residencytraining program the full-time equivalent cap may be adjusted in accordance with the provisions of 42 C.F.R. Regulation 413.79(e)(1) through (e)(4) (Exhibit P-27).This section states that the resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program. Therefore, it would appear that the resident cap would be adjusted to the highest of any program years from fiscal years 2005 through 2008 and the resident count along with the prior years 2009 and 2010 should be stated at the actual amount as the cap has yet to be determined for these years.

The Medicare Contractor contends that the Provider expanded Issues 3 and 4 to add new issues and that the Board lacks jurisdiction over the expanded issues because the expanded issues were not timely included in the subject appeal.

Provider's Position

The Provider contends that the MAC establishes no facts that would undermine the Board's jurisdiction under 42 U.S.C. section 1395oo(a) to consider this appeal. The MAC's Jurisdictional Challenge fails for the following reasons: (1) the MAC does not identify any defect that would undermine the Board's jurisdiction; (2) the Board Rules in place when the Provider submitted its Request for Hearing supports the identification of resident counts as sufficient detail; (3) the Graduate Medical Education ("GME") and Indirect Medical Education ("IME") Base Year FTE Caps are incorporated in and essential to adjudicate both Issue 3 (direct GME reimbursement) and Issue 4 (IME reimbursement) in its Request for Hearing; (4) the Board would consider the Base Year Cap issue in this consolidated appeal, which could then be applied to the fiscal year

ending 2011 through a reopening; (5) the MAC failed to demonstrate that it met and conferred prior to filing this motion, in contravention of Board Rule 44.2, and (6) the Board found it had jurisdiction in a substantially similar jurisdictional challenge with the similar facts.[1]

The Provider asserts that it appropriately identified the GME Base Year Cap in its appeal of adjustment numbers 17, 18, 35, 36, 37, 38, 39, and 40. Provider's Model Form A – Individual Appeal Request states, in relevant part, as follows:

> Whether the Intermediary's adjustment numbers 35, 36, 37, 38, 39, and 40, the exclusion of current and prior years' resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved **base year** amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit **base year** amounts for a provider's approved residency educational program in order to establish an approved **base year** amount per resident and to **properly reimburse current and prior year Graduate Medical Education costs by including the current and prior year resident counts.** The Intermediary has recognized the provider's residency program…[and] has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the cost of approved residents within the provider setting. […] However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

Likewise, the Provider appropriately identified Base Year Caps in its appeal of adjustment number 17 and 18 for issue 4. Specifically, the Provider's Model Form A – Individual Appeal Request states, as follows:

> Whether the Intermediary's adjustment number 17 and 18, the reduction of **prior year resident FTE counts** for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the cost for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulation Sections 412.105 and **413.79.**

Board Decision

Relevant Statutes, Regulations and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in

[1] See Case No. 18-1188 jurisdictional decision issued on April 3, 2020.

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 subject appeal was filed with the Board in 2016 and the regulations effective at the time required the following:

> (b) *Contents of request for a Board hearing.* The provider's request for a Board hearing under paragraph (a) of this subsectionmust be submitted in writing to the Board, and the request must include . . .
>
> (i) An explanation . . . of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, includingan account of…
>
> (ii) Why the provider believes Medicare payment is incorrect for each disputed item . . . [and]
>
> (iii)How and why the provider believes Medicare payment must be determined differently for each disputed item…[2]

Board Rule 8 (July 1, 2015) elaborates on this regulation requiring explanation of issues, stating:

> 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…[3]

GME and IME Base Year Cap (portion of Issue 3 and Issue 4) in Case No. 16-1274

The Provider's Issue Statement #3 in Case No. 16-1274 reads:

> Whether the Intermediary's adjustment numbers 35, 36, 37, 38, 39 and 40, the exclusion of current and prior years' resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved base year amount per resident, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit base year amounts for a provider's approved residency educational program in order to establish an approved base year amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. TheIntermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider

[2] 42 C.F.R. § 405.1835(b) (2013).
[3] Provider Reimbursement Review Board Rules, Rule 8 (2015), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_07_01_2015.pdf

> setting. The Provider has lastly received CMS notification on October 27, 2005 that in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded to the hospital in their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.

Issue Statement #4 reads:

> Whether the Intermediary's adjustment number 17 and 18, the reduction of prior year resident FTE counts for the Indirect Medical Education computation, should be adjusted based on the Intermediary overlap report in that the residents have been assigned to and physically present at the Provider and the Provider has incurred the costs for the residents which is inconsistent with documentation as supplied to the Intermediary by other providers and in accordance with 42 C.F.R. Regulations Sections 412.105 and 413.79.

The Provider claims that its pending appeal relates to GME and IME base year caps. The Provider submitted its 2011 cost report without a Base Year Cap amount because the Base Year caps had not yet been established. The Provider appealed Adjustments Nos. 17, 18, 35, 36, 37, 38, 39, and 40.

> Adjustment No. 17 states "to adjust total allowable FTE count for the prior year to agree with the prior years audited cost report"
>
> Adjustment No. 18 states "to adjust total allowable count for the Penultimate year."
>
> Adjustment No. 35 states "to eliminate Per Resident Amount for GME *since provider cannot support their* ***base year*** *FTE count*."[4]
>
> Adjustment No. 36 states "to remove GME FTEs *since GME* ***Base Year*** *Cost could not be supported*."[5]
>
> Adjustment No. 37 states "to remove the Unweighted FTE count *since GME* ***base year*** *cost was not supported*."[6]
>
> Adjustment No. 38 states "to remove the weighted FTE count *since GME* ***base year*** *cost was not supported*."[7]
>
> Adjustment No. 39 states "to remove the weighted FTE count for prior year *since GME* ***base year*** *cost was not supported*."[8]

[4] (Emphasis added.)
[5] (Emphasis added.)
[6] (Emphasis added.)
[7] (Emphasis added.)
[8] (Emphasis added.)

> Adjustment No. 40 states "to remove the weighted FTE count for the penultimate year *since GME **base year** cost was not supported*."[9]

While these adjustments do not specifically adjust GME and IME Base Year Caps, the Board notes that they do reference the base year and concludes that they are related. Accordingly, the Board finds that it has jurisdiction over the GME and IME Base Year Caps, current and prior year FTEs. The Board **finds** jurisdiction over Issue 3 - GME – Prior Years' FTE Counts and Per Resident Amount and 4-IME – Current Year and Prior Year FTE Counts. The Medicare Contractor, through Audit Adjustment Nos. 35, 36, 37, 38, 39 and 40, has adjusted the cap for GME and, through Audit Adjustment Nos. 17 and 18, has adjusted the cap for IME.

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

Board Members Participating:

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

FOR THE BOARD:

4/13/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, FSS

[9] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Re: ***Jurisdictional Decision***
Adventist Medical Center – Hanford (Prov. No. 05-0121; FYE 12/31/2007)
Case No. 13-2110

Dear Ms. Sze 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 and the Board's jurisdictional determination are set forth below.

Pertinent Facts

Adventist Medical Center – Hanford ("Provider") is a Medicare-certified acute care hospital located in Hanford, California. The Provider's servicing Medicare Administrative Contractor, Noridian Healthcare Solutions, LLC, and Federal Specialized Services, LLC, the Appeals Support Contractor, are together referred to herein as the "MAC."

The Notice of Program Reimbursement ("NPR") for this cost reporting period was issued on November 26, 2012. The Provider filed a hearing request with the Board on May 9, 2013. The Board acknowledged the request on May 17, 2013. The Provider appealed the following issues:

Issue 1: DSH – Medicaid Eligible Indigent Care Days
Issue 2: DSH – Dual Eligible Medicare Advantage Pt C Days - Medicaid Ratio
Issue 3: DSH – Dual Eligible Pt A Exhausted Benefits Days - Medicaid Ratio
Issue 4: DSH – Medicaid Eligible Paid Days
Issue 5: DSH – Dual Eligible Medicare Advantage Pt C Days – SSI Ratio[1]
Issue 6: DSH – SSI – Nursing Home Days[2]
Issue 7: DSH – SSI Accuracy
Issue 8: Medicare GME Managed Care Unbilled Claims

[1] The Provider was directly added to Case No. 13-0764GC. Case No. 13-0764GC was closed on April 21, 2021 via Part C days remand. Therefore, the issue is no longer pending in Case No. 13-2110.
[2] The Provider withdrew this issue on March 19, 2021.

Issue 9: Medicare Bad Debts, Crossover Unbilled
Issue 10: Medicare Bad Debts, Indigent Accounts
Issue 11: GME – Prior Years' FTE Counts and Per Resident Amount
Issue 12: IME – Prior Years' FTE Counts and Intern/Resident to Bed Ratio
Issue 13: GME – Labor Room Days

After the transfer of Issues 1 through 7 and the withdrawal of Issues 9 and 10, only issues 8, 11, 12, and 13 remain in the subject appeal.[3]

Medicare Contractor's Position

On February 4, 2021, the Medicare Contractor ("MAC") filed a jurisdictional challenge alleging that the Provider, in its Preliminary Position Paper filed on January 2, 2014, improperly expanded the scope of the specific items on appeal in both Issues 11 and 12. The Medicare Contractor requests that the Board dismiss: 1) the portions of Issue 11 regarding GME Base Year FTE Cap and GME Current Year Count ; and 2) the portions of Issue 12 regarding the IME Base Year FTE Cap and IME Current Year Count on the basis that the Provider did not appeal these specific items in its Hearing Request but has attempted to improperly add each of these aspects to Issues 11 and 12 through its Preliminary Position Paper filed January 2, 2014.

In its Model Form A – Individual Appeal Request, the Provider stated Issue 11 as:

> Issue #11: Whether the Intermediary's adjustment number 40, the *exclusion of prior years*' Resident full time equivalents (FTE's) for the Graduate Medical Education settlement ***and*** *the approved base year amount per resident*, is in accordance with Regulation Section 413.86(e) which permits the Intermediary to re-audit *base year amounts* for a provider's approved residency educational program in order to establish an approved *base year amount per resident* ***and*** *to properly reimburse current* ***and*** *prior year* Graduate Medical Education costs. TheIntermediary has recognized the provider's residency program as an approved program within the provision of the Provider Reimbursement Manual Section 402. The Intermediary has audited and accepted the provider's IRIS residency diskette, which verifies that the provider has incurred the costs of approved residents within the provider setting. The Provider has lastly received CMS notification on October 27, 2005 that *in accordance with Section 422 of Public Law 108-173 additional DGME and IME FTE slots were awarded* to the hospitalin their expansion of the residency program since 1996. However, the Intermediary has failed to reimburse the provider for any Graduate Medical Education reimbursement.[4]

In its Preliminary Position Paper, the Provider describes Issue 11 to include GME BaseYear FTE Cap (Exhibit C-6, page 5), as follows:

---

[3] *See* Medicare Contractor's Jurisdictional Challenge dated February 4, 2021.
[4] (Emphasis added.)

> The Provider disputes the above disallowance of Graduate Medical Education reimbursement *based on the fact that the base year residents were to be calculated per the Joint Scheduling Order for PRRB Case No 04-0100 (Exhibit P-43)*. The Intermediary was to determine the number of residents per the IRIS diskette for the computation of base year amount. The Provider is awaiting the determination of the resident count.
>
> Furthermore, *in accordance with Section 422(a) of Public Law 108-173* a hospital may receive an increase in its FTE resident cap as a result of the agency's redistribution of unused resident positions. The hospital requested and received on October 27, 2005 additional DGME and IME slots pursuant to section 422 of Public Law 108-173 (Exhibit P-45).[5]

Regarding Issue 12, the Provider stated the issue in its Hearing Request as:

> Issue #12. Whether the Intermediary's adjustment numbers 37, 38 and 39, the inclusion of *prior years'* resident FTE's and the *Prior Year* Ratio of Residents to Available Beds for the Indirect Medical Education computation, should be adjusted based on any future settlements of the Provider Reimbursement ReviewBoard decisions. *The two prior year settlements for fiscal years December 31, **2005** and December 31, **2006** do not reflect resident counts for the provider's CMS approved expanded residency program in accordance with Section 422 of Public Law 108-173 for additional IME FTE slots*. Therefore, the prior years' residents have been understated along with the prior year ratio of resident to bed ratio. It is the provider's opinion that the Intermediary interpretation of the regulations is not within congress intent to adequately reimburse providers for approved medical education.

In its Preliminary Position Paper, the Provider described Issue 12 to include the IME BaseYear FTE Cap, pages 60 and 61 (Exhibit C-6, pages 10 and 11), as follows:

> As stated in the previous issue on GME reimbursement, the Provider *initiated a new approved residency program on July 1, **2005*** with Loma Linda University Medical Center. This new residency program preceded the merger with Selma Community Hospital which had a residency program *for which the base year resident count was not reflective of the increase in the training programs through the last ten years*. As the new program started on July 1, 2005, which is attached to Provider Number 05-0121 prior to the merger of Provider Number 05-0470, *a new IME*

[5] (Emphasis added.)

> *reimbursement settlement should have been incorporated in accordance with 42 C.F.R. Regulation Section 412.105(a)(ii) (Exhibit P-50) which provides for an exception for new programs for which the full time equivalent cap may be adjusted based on the period of years equal to the minimum accredited length of each new program*. Section 412.105(f)(vii) states that in a new medical residencytraining program the full-time equivalent cap may be adjusted in accordance with the provisions of 42 C.F.R. Regulation 413.79(e)(1) through (e)(4) (Exhibit P-58).This section states that the resident cap may be adjusted based on the product of the highest number of residents in any program year during the third year of the first program's existence for all new residency-training programs and the number of years in which residents are expected to complete the program. Therefore, *it would appear that the resident cap would be adjusted to the highest of any program years from fiscal years 2005 through 2008 and the resident count along with the prior years 2005 and 2006 should be stated at the actual amount as the cap has yet to be determined for these years*.[6]

The Medicare Contractor maintains that the Provider expanded Issues 11 and 12 to include new issues and that the Board lacks jurisdiction Issues 11 and 12 because these expanded issues were not timely included in the subject appeal.

Provider's Position

The Provider contends that the MAC establishes no facts that would undermine the Board's jurisdiction under 42 U.S.C. section 1395oo(a) to consider this appeal. The MAC's Jurisdictional Challenge fails for the following reasons:

(1) The MAC does not identify any defect that would undermine the Board's jurisdiction;

(2) The Board Rules in place when the Provider submitted its Request for Hearing supports the identification of resident counts as sufficient detail;

(3) The Graduate Medical Education ("GME") and Indirect Medical Education ("IME") Base Year FTE Caps are incorporated in and essential to adjudicate both Issue 11 (direct GME reimbursement) and Issue 12 (IME reimbursement) in its Request for Hearing;

(4) The Board would consider the Base Year Cap issue in this consolidated appeal, which could then be applied to the fiscal year ending 2007 through a reopening;

(5) The GME Current Year FTE count is incorporated in and essential to adjudicate Issue 11 and also incorporated via the GME Base Year Cap issue;

(6) The IME Current Year FTE count is incorporated in the IME Base Year Cap issue;

(7) The MAC failed to demonstrate that it met and conferred prior to filing this motion, in contravention of Board Rule 44.2, and

[6] (Emphasis added.)

(8) The Board found it had jurisdiction in a substantially similar jurisdictional challenge with the similar facts.[7]

The Provider asserts that it appropriately identified the GME Base Year Cap in its appeal of Audit Adjustment No. 40. The Provider's Model Form A – Individual Appeal Request states, in relevant part, as follows:

> Whether the Intermediary's adjustment number 40, the exclusion of prior years' Resident full time equivalents (FTE's) for the Graduate Medical Education settlement and the approved **base year** amount per resident, is in accordance with Regulation Section 413.86(e) which permitsthe Intermediary to re-audit **base year** amounts for a provider's approved residency educational program in order to establish an approved **base year** amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. […] However the Intermediary hasfailed to reimburse the provider for any Graduate Medical Education reimbursement.

Likewise, the Provider asserts that it appropriately identified Base Year Caps in its appeal of adjustment number 21, 22, and 23[8] for issue 12. Specifically, the Provider's Model Form A – Individual Appeal Request states, as follows:

> Whether the Intermediary's adjustment numbers 37, 38 and 39, **the inclusion of prior years' Resident FTE's** and the Prior Year Ratio of Residents to Available Beds for the Indirect Medical Education computation, should be adjusted based on any future settlements of the Provider Reimbursement Review Board decisions. The two prior year settlements for fiscal years December 31, 2005 and December 31, 2006 do not reflect resident counts for the provider's CMS approved expanded residency program in accordance with Section 422 of Public Lab 108-173 for additional IME FTE slots. Therefore the prior years' residents have been understated along with the prior year ratio of resident to bed ratio. It is the provider's opinion that the Intermediary interpretation of the regulations is not within congress intent to adequately reimburse providers for approved medical education.

Board Decision

Relevant Statutes, Regulations and Board Rules

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

[7] See Case No. 18-1188 jurisdictional decision issued on April 3, 2020.
[8] The parties agree that the appropriate adjustments are 21,22, and 23. *See* Provider's Opposition to Jurisdictional Challenge at 8.

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 daysof the date of receipt of the final determination.

The subject appeal was filed with the Board in 2013 and the regulations required the following:

> (2) (b) *Contents of request for a Board hearing.* The provider's request for a Board hearing under paragraph (a) of this subsectionmust be submitted in writing to the Board, and the request must include . . .
>
> (i) An explanation . . . of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, includingan account of…
>
> (ii) Why the provider believes Medicare payment is incorrect foreach disputed item . . . [and]
>
> (iii)How and why the provider believes Medicare payment must be determined differently for each disputed item…[9]

Board Rule 8 (March 1, 2013) elaborates on this regulation requiring explanation of issues, stating:

> 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…[10]

GME and IME Base Year Cap (portion of Issue 11 and Issue 12) in Case No. 13-2110

The Provider's Issue Statement #11 in Case No. 13-2110 reads:

> Whether the Intermediary's adjustment number 40, the exclusion of *prior years'* Resident full time equivalents (FTE's) for the Graduate Medical Education settlement ***and*** the approved *base year* amount per resident, is in accordance with Regulation Section 413.86(e) which permitsthe Intermediary to re-audit ***base year*** amounts for a provider's approved residency educational program in order to establish an approved ***base year*** amount per resident and to properly reimburse current and prior year Graduate Medical Education costs. […] However the Intermediary hasfailed to reimburse the provider for any Graduate Medical Education reimbursement.[11]

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[9] 42 C.F.R. § 405.1835(b) (2013).
[10] Provider Reimbursement Review Board Rules, Rule 8 (2013), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRULES_03_01_2013.pdf
[11] (Emphasis added.)

Issue Statement #12 reads:

> Whether the Intermediary's adjustment number 37, 38, and 39, **the inclusion of prior years' Resident FTE's** and the Prior Year Ratio of Residents to Available Beds for the Indirect Medical Education computation, should be adjusted based on any future settlements of the Provider Reimbursement Review Board decisions. The two prior yearsettlements for fiscal years December 31, 2005 and December 31, 2006 do not reflect resident counts for the provider's CMS approved expanded residency program *in accordance with Section 422 of Public Lab 108-173 for additional IME FTE slots*. Therefore the prior years' residents have been understated along with the prior year ratio of resident to bed ratio. It is the provider's opinion that the Intermediary interpretation of the regulations is not within congress intent to adequately reimburse providers for approved medical education.[12]

The Provider claims that its pending appeal relates to GME and IME base year caps. The Provider submitted its 2007 cost report without a Base Year Cap amount because the Base Year caps had not yet been established. The Provider appealed Adjustments Nos. 40, 21, 22, and 23:

> Adjustment No. 40 states "To remove the as-filed GME counts from Worksheet E-3, Part IV. ***The Base Year could not be supported***, thus GME cannot be claimed."
>
> Adjustment No. 21 states "*To remove the FTE count* for allopathic and osteopathic programs."
>
> Adjustment No. 22 states "To adjust IME FTE resident counts used in the calculation of the current year's rolling average."
>
> Adjustment No. 23 states "To adjust the prior year I&R to bed ratio."

While these adjustments do not specifically adjust GME and IME Base Year Caps, they do refer to the base year the Board concludes that they are related. Accordingly, the Board finds that it has jurisdiction over the GME and IME Base Year Caps, current and prior year FTEs.

The Board **finds** jurisdiction over Issue 11 - GME – Prior Years' FTE Counts and Per Resident Amount and 12-IME – Prior Years' FTE Counts and Intern/Resident to Bed. The Medicare Contractor, through Audit Adjustment No. 40, has adjusted the cap for GME and, through Audit Adjustment No. 21, has adjusted the cap for IME. The Board also notes that the issue statement for Issue 11 references the base year amount per resident and the issue statement for Issue 12 references the prior year FTEs and the intern to bed ratio that are impacted by the cap.

[12] (Emphasis added.)

The Board also notes that in the issue statement for Issue 12 the Provider incorrectly references adjustments 37, 38, and 39 that do not relate to IME and in the preliminary position paper corrects this and references adjustments 21, 22 and 23 that are related to IME.

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

Board Members Participating:

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

FOR THE BOARD:

4/13/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

J.C. Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Ste. 570A
Arcadia, CA 91006

RE: ***Jurisdictional Decision***
Carolinas Medical Center (Prov. No. 34-0113)
FYE 12/31/2008
Case No. 14-1203

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Medicare Contractor's motion to dismiss the above-captioned appeal for Carolinas Medical Center ("Carolinas" or "Provider"). The Board's analysis and determination is set forth below.

Pertinent Facts

On December 3, 2013, the Provider's representative, Quality Reimbursement Services, Inc. ("QRS") timely filed Carolinas' request for hearing on a Notice of Program Reimbursement ("NPR") dated June 5, 2013 for fiscal year ("FY") 2008. The hearing request only included one issue:

- Issue 1: Outlier Payments – Fixed Loss Threshold

On December 27, 2013, the Board acknowledged the appeal and notified the parties that Carolinas preliminary position paper ("PPP") was due on August 1, 2014 and that the Medicare Contractor's PPP was due on December 1, 2014.

On February 3, 2014, QRS timely filed a request to add the following six issues to Carolinas' appeal:

- Issue 2: Disproportionate Share Hospital (DSH) Medicaid Eligible Days
- Issue 3: DSH Medicare Part C Days – Medicare/Medicaid Fraction
- Issue 4: DSH Medicaid Labor & Delivery Days
- Issue 5: DSH Dual Eligible Days Exhausted Part A – Medicare/Medicaid Fraction
- Issue 6: DSH Medicaid Eligible Observation Days
- Issue 7[1]: Medicare Charity Bad Debts

Significantly, the add-issue request estimated the reimbursement impact of Issues 2 through 6 to ***each*** be $19,243 based on an estimated 50 days increase in the Medicaid fraction for *each* issue. The estimated impact for Issue 7 was stated as $70,000.

[1] The Provider listed the issues as 1 through 6 on the February 3, 2014 letter.

On August 1, 2014, QRS timely filed Carolinas' PPP. Similarly, on November 26, 2014, the Medicare Contractor timely filed its PPP.

On May 22, 2017, Carolinas transferred Issues 1, 3, 4, and 5 to common issue related party ("CIRP") group appeals (Case Nos. 14-3804GC, 14-4029GC, 14-3775GC, and 14-4030GC respectively). On December 19, 2014, QRS withdrew Issue 6. On March 6, 2021, QRS withdrew Issue 7. As a result of these transfers and withdrawals, the only remaining issue is Issue 2 – DSH Medicaid Eligible Days.

On September 28, 2020, the Board issued notice to the parties that Carolinas must file its final position paper ("FPP") by March 6, 2021 and that the Medicare Contractor must file its FPP by April 5, 2021. This notice gave the following instruction regarding the content of Carolinas' FPP:

> Provider's Final Position Paper – For each remaining issue, the position paper **must state the material facts that support the appealed claim**, identify the controlling authority (e.g., statutes, regulations, policy, or case law), and provide arguments applying the material facts to the controlling authorities. **This filing must also include any exhibits the Provider will use to support its position**. ***See*** **Board Rule 27 for more specific content requirements**. If the Provider misses its due date, the Board will dismiss the cases.[2]

On March 6, 2021, QRS timely filed Carolinas' FPP. On April 1, 2021, the Medicare Contractor timely filed its FPP.

On May 23, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 79 months since the appeal was filed.

On June 3, 2022, QRS filed its response to the Medicare Contractor's Motion to Dismiss. QRS acknowledged that it had not submitted a listing of additional Medicaid eligible days being claims in this appeal but asserted that it had not abandoned the appeal because it was having difficulty in obtaining documentation from the state of North Carolina. QRS maintains that its difficulties in obtaining information from North Carolina warrant a postponement of this case.

Specifically, QRS describes these difficulties as follows:

---

[2] (Bold emphasis added and footnote omitted.)

> *QRS **has made** the following efforts with the State*:
>
> ***On July 28, 2020***, *QRS requested for the eligibility listing to be sent directly to the MAC* from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates *to those **older voided** segments* in the immediate future.
>
> ***On May 11, 2021***, QRS *reached out* to the State contact *for an update* to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is *now a workable databas*e but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.
>
> QRS continues to work with the State to develop an alternative method to fix the deficiencies. *The last discussions took place in May and June of 2022*. Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution. As such, QRS respectively requests for a postponement.
>
> 1. One final point is that on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013. As already noted, the MAC has challenged this appeal by taking the position that has not moved forward with the review process. Based on this challenge, the MAC does not agree with this postponement request. However, this challenge appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time.
>
> For the reasons discussed above, the Provider hereby requests a 180-day postponement of case number 14-1203.[3]

QRS included one exhibit in support of its postponement request. This exhibit is 2 pages consisting of 3 emails between QRS and North Carolina dated July 28, 2020, May 11, 2021, and May 13, 2021. It is unclear if 3 emails are a chain (*i.e*., no intervening emails) or are separate emails that were spliced together in one document/exhibit.

[3] (Emphasis added.)

Board's Analysis and Decision:

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

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

However, when QRS filed the February 4, 2014 request to add Issue 2 to Carolinas' appeal, QRS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

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

> (b) *Position papers.* . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue**.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[4]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[5] Board Rule 25 (2018) gives the following instruction on the content of position papers:

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

Rule 25 Preliminary Position Papers

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline*.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

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

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

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

****

25.2 Position Paper Exhibits

24.2.1 General

With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (*see* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

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

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its final position paper and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of § 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because QRS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days).[6] In this regard, the Board notes that the Provider represented in its final position paper filed on March 6, 2021 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[7] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding QRS' representation that such a listing was available and ready.

The Board recognizes that, in its June 3, 2022 postponement request, QRS purports to *belatedly* provide information that it should have provided in its final position paper per Board Rule 25.2.2. Regardless of the ***untimely*** nature of this information, it is wholly inadequate and fatally flawed. In the postponement request, QRS now represents that, contrary to its representation in Carolinas' FPP that a listing had been

[6] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[7] Final Position Paper at 11.

completed, it had not yet been able to do a listing because, when it began trying to pull the data in July 2020, it experienced problems with the State. While QRS *represents* that it learned on July 28, 2020 that documentation was unavailable from the State Medicaid program, it failed to notify the Board or the opposing party in its final position paper as required by Board Rule 25.2.[8] Indeed, QRS did not even follow up with the State Medicaid Program until almost 10 months later on May 21, 2021 (more than 2 months ***after*** it had filed the Provider's final position paper). The Board again notes that, when Carolinas' FPP was filed on March 6, 2021, this appeal had been pending *for over seven (7) years*.

Further, there are multiple issues with QRS' *untimely* allegation that it has experienced problems obtaining supporting data from the State to identify ***any*** Medicaid eligible days at issue. First, neither QRS' extension letter nor the exhibit attached to it explain what the alleged State database problems are or when it began. Second, when the FFP was filed, it had been ***more than 12 years*** *since the close of Carolinas' FY 2008*. As a result, it is clear that neither Carolinas nor QRS were diligent in developing the merits of the 2008 Medicaid eligible days issue *by waiting* ***11+ years*** *until July 2020* to begin the process of identifying potential Medicaid eligible days to dispute.

Third, notwithstanding QRS' assertion in its postponement request, it is not clear that QRS began work with the State on the Carolinas' 2008 Medicaid eligible days issue. The email QRS includes to support its July 28, 2020 start date does not even relate to Carolinas but rather to another provider, Cape Fear for Cape Fear's FY 20**10** and a report run for Cape Fear 4 years prior, in 2016.[9] Accordingly, the Board questions whether QRS was even attempting to identify 200**8** Medicaid eligible days in dispute for Carolinas' FY 200**8** (which is another year entirely different from Cape Fear and for which QRS initiated work back in 2016).

Fourth, it is not clear what "problems" were being encountered with the State database and, given the fact that by July 2020, it had been more than 11 ½ years since the end of Carolinas' FY 2008, it is not surprising that the State data at issue was on an archived database as confirmed by the following excerpt from the July 28, 2020 email from the State:

> Are you talking about the Cape Fear report run back in 2016? I see one from April 1, 2016 and another one from May 26, 2006. I do still have those reports. Copying Carrina to see if this is something that she is able to approve. Also, *I don't see any updates to those* ***older voided segments*** anytime soon based on the response from the eligibility group.[10]

Accordingly, it is unclear. For example, by 2020, it is likely that the State had not maintained the 2008 data in its live database and that the issues being experienced were with an archived database. Had QRS or Carolinas been diligent in attempting to identify the Medicaid eligible days instead of waiting

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[8] In this regard, the Board notes that, as discussed *infra*, the July 28, 2020 email does not even relate to Carolinas or to 2008 but to another provider, Cape Fear for 2010. As a result, this could explain why it was not mentioned in Carolinas FPP, meaning that QRS had not actually begun work with the State on the Carolinas 2008 Medicaid eligible days issue.

[9] The July 28, 2010 email relates to another provider, Cape Fear, as noted by the reference to Cape Fear in the body of the email as well as the re: line entitled "Cape Fear 2010." Indeed, this email suggests that QRS began work on Cape Fear 4 years earlier back in 2016. In contrast, there is no evidence to suggest that QRS began to work with the State on Carolinas in either 2016 or in 2020 other than QRS' bald assertion.

[10] (Emphasis added.)

apparently 11+ years to begin to identify those days, would it have experienced the same problems? It is unclear from the record and, due to the excessive passage of time and lack of diligence, the Board must assume that the alleged "problems", if true, would *not* have been an issue.

Finally, the QRS' claim that, due to a moratorium on certain administrative resolutions ("ARs"), the Medicare Contractor may not enter into an AR for this case at this time on the Medicaid eligible days issue *has nothing to do with* ***the Provider's responsibility*** *to develop the record*. Moreover, even if the Medicare Contractor may not enter into an AR *at this time*, it does not prevent the Medicare Contractor from reviewing any submitted days listing, and finalizing that audit work and any resulting proposed adjustments in anticipation of a future AR in anticipation of the moratorium being lifted. Therefore, the inability to sign an AR, does not negate the fact that QRS has a responsibility to develop the merits of its case and that, notwithstanding that responsibility and the fact that this case has been pending now for 9+ years, it has been unresponsive to the MACs request for the Medicaid eligible days listings.

Based on the above, the Board finds that the Provider has failed to provide a Medicaid eligible days listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2). Nor has the Provider provided any *timely* explanation to the MAC,[11] as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. Indeed, the Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[12] Accordingly, the Board must conclude that there are no days at issue and that the amount in controversy is $0.

As such, the Board dismisses the Medicaid Eligible Days issue from the appeal. As this is the sole remaining issue in the appeal, the Board closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

4/14/2023

X Clayton J. Nix

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

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

[11] As explained *supra*, the June 3, 2022 explanation is both untimely and fatally flawed.

[12] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.

Dana Johnson, National Government Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Via Electronic Delivery

Nan Chi, Director of Budget & Compliance
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: ***Board Decision***
Houston Methodist Hospital (Prov. No. 45-0358)
FYE 12/31/2011
Case No. 17-1060

Dear Ms. Chi,

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-1060 in response to a jurisdictional challenge filed by the Medicare Contractor. The Board's decision is set forth below.

Background

A. Procedural History for Case No. 17-1060

On February 16, 2017, Houston Methodist Hospital ("Provider"), appealed a Notice of Program Reimbursement (NPR) dated August 25, 2016, for its fiscal year end ("FYE") December 31, 2011 cost reporting period. The Provider appealed the following 12 issues, which are listed below in order as they appear in the Office of Hearings Case and Document Management System ("OH CDMS") (this order is different than the order listed in the Provider's Appeal Request):[1]

- Issue 1: DSH and IME Capital Reimbursement
- Issue 2: DSH SSI Percentage (Provider Specific)
- Issue 3: DSH SSI Percentage (Systemic Errors)[2]
- Issue 4: DSH – SSI Fraction/Medicare Managed Care Part C Days[3]
- Issue 5: DSH – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[4]
- Issue 6: DSH Medicaid Eligible Days[5]

[1] Provider's Request for Hearing, Tab 3, Appeal Issues (Feb. 16, 2017).
[2] Transferred to Case No. 15-2932GC.
[3] Transferred to Case No. 15-2924GC.
[4] Transferred to Case No. 15-2929GC.
[5] Withdrawn on August 14, 2019.

- Issue 7: DSH – Medicaid Fraction/Medicare Managed Care Part C Days[6]
- Issue 8: DSH – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[7]
- Issue 9: LIP Medicaid Eligible Days
- Issue 10: LIP SSI Percentage
- Issue 11: Bad Debts[8]
- Issue 12: Weighting of Residents for DGME Payment[9]

As the Provider is commonly owned, it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). On October 20, 2017, Issues 3-5 and 7-8 were transferred to CIRP group cases consistent with its obligations under § 405.1837(b)(1). On August 14, 2019, September 21, 2021, and November 26, 2019, the Provider withdrew Issues 6, 11, and 12 respectively. As a result of these transfers and withdrawals, only Issues 1-2 and 9-10 remain open in this case.

On April 17, 2018, the Medicare Contractor filed a Jurisdictional Challenge on April 17, 2018, addressing the following issues: Issue 2, the DSH SSI Percentage (Provider Specific) issue; Issue 9, the LIP Amount Calculation; and Issue 10, the LIP SSI Percentage.

On May 10, 2018, the Provider timely responded to the jurisdictional challenge.

On January 10, 2023, the Provider filed its final position paper ("FPP"). Similarly, on February 3, 2023, the Medicare Contractor filed its FPP.

On March 6, 2023, the Provider filed a hearing postponement request due to "pending Board ruling on outstanding issues."

B. Descriptions of Issues 2 and 3 in the Appeal Request and the Provider's Participation in Case No. 15-2932GC

In its Individual Appeal Request, the Provider summarizes its DSH SSI Percentage (Provider Specific) issue (Issue 2) as follows:

> [T]he MAC [(Medicare Administrative Contractor)] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[10]

[6] Transferred to Case No. 15-2928GC.
[7] Transferred to Case No. 15-2931GC.
[8] Withdrawn on September 21, 2021.
[9] Withdrawn on November 26, 2019.
[10] Provider's Request for Hearing, Tab 3

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[11] The Provider also "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period," citing 42 U.S.C. § 1395(d)(5)(F)(i). The amount in controversy for this issue was listed as $207,019.[12]

Also in its Individual Appeal Request, the Provider describes the DSH SSI Percentage (Systemic Errors) issue (Issue 3) as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ["*Baystate*"]and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[13]

The amount in controversy for this issue was listed as $207,019.[14] This issue was transferred to the CIRP group under Case No. 15-2932GC on October 20, 2017. In CIRP Group Case No. 15-2932GC is entitled "*QRS Houston Methodist 2011 DSH SSI Percentage (Systemic Errors) CIRP Group*" and the Providers describe the group issue the exact same way as the issue is described above, in the instant appeal.

On January 10, 2023, the Provider filed its FPP in the instant case, which included a description of all of the issues in the appeal, including Issues 2 and 3, which is ***identical*** to how they were

[11] *Id.*
[12] *Id.*
[13] *Id*.
[14] *Id.*

described in the Initial Appeal Request, and quoted above. While the Provider addressed all of the issues in its FPP, as discussed above, only Issues 1-2 and 9-10 remain open in this case.

MAC's Contentions

Issue 2 – DSH SSI Percentage (Provider Specific)

The MAC contends that the DSH SSI Percentage (Provider Specific) issue should be dismissed because it is duplicate of the DSH SSI Percentage (Systemic Errors) issue. The MAC explains that the Provider is making essentially the same argument in these two issues, as the Provider contends that the SSI ratio applied to its cost report was incorrect and the SSI ratio is the underlying dispute in both of these issues. The MAC asserts that under Board Rules, the Provider is barred from filing a duplicate SSI percentage issue.

The MAC asserts that this issue also includes the Provider's subsidiary appeal over SSI realignment, and that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, it is not a final intermediary determination. The MAC asserts that the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3), and therefore, the Provider's appeal is premature.

Issues 9 and 10 – LIP Medicaid Eligible Days and LIP SSI Percentage

The MAC asserts that the Board should dismiss Issues 9 and 10 because it lacks subject matter jurisdiction over these two issues. The MAC explains that the Provider has challenged the accuracy of the Inpatient Rehabilitation Facility ("IRF") Low Income Patient ("LIP") adjustment, which is a facility-level adjustment for low income patients that takes into account both the percentage of Medicare patients who are receiving Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. The purpose of the LIP adjustment is to pay IRFs more accurately for the incremental increase in Medicare costs associated with the facility's percentage of low income patients.

The IRF prospective payment rate is based on the average payment per payment unit for inpatient operating and capital costs of rehabilitation facilities. The Secretary must adjust the rate by specific designated factors and such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among IRFs. The prospective payment rate for IRFs is therefore a product of (1) a rate based on historical costs, and (2) adjustments to that rate based on factors set forth in the statute, and one of the adjustments to the rate is the LIP adjustment.

The MAC asserts that the LIP adjustment is a component of the IRF prospective payment rate established under § 1886(j)(3) of the Social Security Act (the "Act"). Therefore, the Board is precluded from reviewing these two issues involving the LIP adjustment because § 1886(j)(8)(B) of the Act specifically precludes administrative and judicial review of prospective payment rates established under § 1886(j)(3) of the Act.

Provider's Response

Issue 2 – DSH SSI Percentage (Provider Specific)

The Provider asserts that, pursuant to Board Rule 8.1, some issues may have multiple components and each component must be appealed as a separate issue. In the instant case, the Provider asserts that Issues 2 and 3 represent different components of the SSI issue, so the Board should find jurisdiction over both issues.

The Provider explains that the SSI Systemic Errors issue (Issue 3) addresses the various errors discussed in *Baystate* in CMS' calculation of the disproportionate payment percentage, which resulted in the MedPAR not reflecting all individuals who are eligible for SSI. The Provider contends that these systematic errors were the result of CMS' improper policies and data matching process, and this issue also covers CMS Ruling 1498-R.

The Provider contends that in the SSI Provider Specific issue (Issue 2), it is not addressing errors that result from CMS' improper data matching process but instead, it is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider notes that in *Baystate*, the Board also considered whether, independent of these systemic errors, Baystate's SSI fractions were understated due to the number of days included in the SSI ratio.

Issues 9 and 10 – LIP Medicaid Eligible Days and LIP SSI Percentage

The Provider argues that while the IRF LIP adjustment contains a prospectively determined adjustment factor (percentage or formula containing a predetermined exponent), the LIP adjustment formula also contains hospital-specific components. The hospital-specific components are prospectively based on prior year cost report amounts for interim payment purposes, however, they are retrospectively adjusted upon final settlement of the cost report.

The Provider explains that hospital-specific components, *i.e.*, SSI percentage and Medicaid percentage, are defined elsewhere within the Act in relation to Inpatient Prospective Payment, as CMS has borrowed from existing payment methodologies in developing the IRF prospective payment system ("PPS") § 1886(j)(3)(v) adjustment factors for variations in costs. These hospital-specific factors, with established definitions and administrative and judicial review rights in other areas of the Act and the regulations, are not prospectively established rates. The Provider asserts that the preclusion of review, if applicable at all, would apply to the formulas used in the IRF-PPS payments and adjustment and uniform Federal rates, not individual hospital-specific rates which are set on an interim basis and then settled retrospectively upon settlement.

Board Analysis and Decision

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

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

A. Issue 2 -- DSH SSI Percentage (Provider Specific)

The analysis for Issue 2 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 2

The first aspect of Issue 2—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Error) issue (Issue 3) that was transferred to CIRP Group Case No. 15-2932GC.

The DSH SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the [MAC] used the correct [SSI] percentage in the [DSH] calculation."[15] The Provider's legal basis for its DSH SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17]

As the Provider is subject to the mandatory CIRP regulation, the Provider transferred the DSH SSI Percentage (Systemic Errors) issue to CIRP Group Case No. 15-2932GC. Significantly, the transferred issue also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue (Issue 2) in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) issue in Case No. 15-2932GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5[18], the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-2932GC. Further,

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[15] Provider's Request for Hearing, Tab 3
[16] *Id.*
[17] *Id.*
[18] Board Rules v. 1.3 (July 2015). At the time of the February 2017 filing of the appeal in this case, the July 1, 2015 version of the Board Rules were in effect.

any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[19] The Provider is misplaced in referring to Issue 2 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed as Issue 3 and transferred to Case No. 15-2932GC. Further, contrary to the Provider's assertion the Board in *Baystate* did not "consider[] whether independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI Ratio."[20] A review of the Board's decision in *Bastate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006) confirms that the Board did not consider non-systemic issues and the references to omitted records were identified and discussed as "systemic issues" covering five areas:

> 1. the omission of inactive SSI records at least through 1996;
> 2. the omission of SSI records relating to individuals who received a forced payment from an SSA field office;
> 3. the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;
> 4. the omission of SSI days associated with individuals whose benefits were granted or restored retroactively after SSA ran each year's tape; and,
> 5. the omission of individuals who were entitled to non-cash Federal SSI benefits.[21]

Regardless, the Provider has the burden to identify the alleged non-systemic issues and has failed to do so and a generic reference to *Baystate* does not satisfy that burden.

To this end, the Board also reviewed the Provider's FPP to see if it further clarified Issue 2. In this regard, the Board notes that its regulations and rules address the Provider's obligation to develop the merits of each issue and to provide all relevant supporting documentation. 42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §

[19] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[20] Provider's Jurisdictional Response at 2 (citation omitted).
[21] PRRB Dec. No. 2006-D20 at 23.

> 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe* ***to be decided by the Board*** *through a schedule applicable to a specific case or through general instructions*.[22]

As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Similarly, regarding position papers,[23] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[24] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[25]

Here, the Provider failed to develop the meris of Issue 1 in its final position paper and, in particular, failed to provide any basis upon which to distinguish Issue 2 from the SSI issue in Case No. 15-2932GC, but instead reiterates the language in its appeal request. Specifically, the Board finds that the Provider's FPP failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. The Provider failed to *fully* develop the merits of its position on Issue 2 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits; in fact, the Provider included the exact same language as its Appeal Request and did not further develop any arguments.

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

The Board recognizes that the Provider states in its FPP that it is "seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination fo the SSI percentage." However, the Provider failed to comply with Board Rule 25.2.2 because it failed to: (1) specifically identify the missing documents; (2) explain why they remain unavailable; (3) state the efforts made to obtain the document; and (4) indicate when they will be available. Moreover, the Board notes that certain information is readily available and it is unclear whether and to what extent the Provider has reviewed this available information. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[26]16
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[27]

Accordingly, *based on the record before it*, the Board finds that Issue 2 in the instant appeal and the group issue in Case No. 15-2932GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 2*

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its

[26] Last accessed February 24, 2023.
[27] Emphasis added.

intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment. As such, there is no "determination" to appeal and the appeal of this issue is otherwise premature. For this reason, the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. Accordingly, Issue 2 is dismissed in entirety.

B. Issues 9 and 10 -- LIP Medicaid Eligible Days and LIP SSI Percentage

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates for IRFs. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar*[28], answers this question and clarifies what is shielded from review.

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 served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the D.C District Court, wherein the Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[29] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[30]

In the instant appeal, the Provider seeks Board review of several components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI Ratio and the treatment of Medicaid Eligible days as they specifically relate to the LIP adjustment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses these two issues in the instant appeal. In making this finding, the Board notes that the D.C. Circuit decision in *Mercy* is controlling precedent on the interpretation and application of the statute at issue because the Provider could bring suit in the D.C. Circuit.[31]

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[28] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).
[29] *Mercy Hosp., Inc. v. Burwell*, 206 F.Supp.3d 93, 102-103 (D.D.C. 2016).
[30] *Mercy*, 891 F.3d at 1068.
[31] 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

C. Issue 1 -- DSH and IME Capital Reimbursement

After the Board's determinations on the MAC's jurisdictional challenge, discussed above, the only remaining issue in this case is Issue 1. The Provider describes the remaining issue (DSH and IME Capital Reimbursement) as asking the Medicare Contractor to incorporate the resolution of the DSH issues in this appeal to the determination of the Capital reimbursement amount. In its FPP, the Medicare Contractor agrees that any adjustments arising from the applicable DSH issues should be incorporated into the calculation of the Capital DSH amount. The Medicare Contractor noted that the results of the operating DSH calculation on Worksheet E, Part A, will automatically flow to Worksheet L for the calculation of Capital DSH.

The Provider's description of Issue 1 relates ***only*** to the updating of the Capital DSH calculation. As any adjustment to the SSI Percentage/DSH calculation made for operating DSH on worksheet E Part A will automatically flow to Worksheet L for the calculation of Capital DSH, as noted by the Medicare Contractor, Issue 1 (DSH and IME Capital Reimbursement) does ***not*** present an issue that requires a Board determination. Specifically, this issue is not a "dissatisfaction" with a specific aspect of the final contractor determination, but rather, it is for the purpose of ensuring the specific aspects contested in the *other* issues in the appeal are calculated properly if those specific aspects of the final contractor's determination contested in those other issues are found by the Board to have been determined incorrectly. Thus, this issue does not meet the content requirements for a request for a Board hearing on a final contractor determination under 42 C.F.R. § 405.1835(b)(2). Accordingly, the Board dismisses Issue 1.

****

In summary, the Board hereby dismisses the SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 15-2932GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board hereby dismisses the two LIP adjustment issues (Issues 9 and 10) because these issues are statutorily precluded from administrative review. Finally, the Board dismisses Issue 1, which relates only to the updating of the Capital DSH calculation if other DSH issues in the appeal are found by the Board to have been determined incorrectly by the Medicare Contractor, as it does not meet the content requirements for a request for a Board hearing under the regulation. As no issues remain pending, the Board hereby closes Case No. 17-1060 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.

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).

Board Members Participating:

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

For the Board:

4/14/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

J.C. Ravindran
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Arcadia, CA 91006

RE: ***Jurisdictional Decision***
Carolinas Medical Center (Prov. No. 34-0113)
FYE 12/31/2009
Case No. 14-2767

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the Medicare Contractor's motion to dismiss request. The Board's analysis and determination is set forth below.

Pertinent Facts

Carolinas Medical Center submitted a request for hearing on February 28, 2014 from a Notice of Program Reimbursement ("NPR") dated September 4, 2013. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Medicaid Eligible Days
- Issue 2: DSH Medicare Part C Days – Medicare/Medicaid Fraction
- Issue 3: DSH Medicaid Labor & Delivery Days
- Issue 4: DSH Dual Eligible Days Exhausted Part A – Medicare/Medicaid Fraction
- Issue 5: DSH Medicaid Eligible Observation Days
- Issue 6: Outlier Payments-Fixed Loss Threshold

On October 9, 2014, the Provider transferred Issues 2, 4, and 6 to group appeals. On October 31, 2014, the Provider withdrew Issue 3. On May 20, 2015, the Provider withdrew Issue 5. The only remaining issue is Issue 1 – DSH Medicaid Eligible Days.

On September 28, 2020, the Board issued a Notice of Hearing and Critical Due Dates setting a hearing for June 4, 2021 and set due dates for final position papers. On March 6, 2021, the Provider timely filed its final position paper. Similarly, on April 1, 2021, the Medicare Contractor timely filed its final position paper. On May 20, 2021, the Provider's representative Quality Reimbursement Services ("QRS") filed a request for postponement of the hearing for 180 days stating that it "is finalizing a listing [of Medicaid eligible days] for submission to the MAC." The Board granted the postponement and rescheduled the hearing for January 5, 2022.

On December 29, 2021, QRS filed a second request for postponement for 180 days stating that it "is finalizing a listing for submission to the MAC but is experiencing a delay in receiving eligibility listing by the State." The Board granted postponement and rescheduled the hearing for June 6, 2022.

On May 23, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 79[1] months since the appeal was filed.

The Provider's representative, Quality Reimbursement Services ("QRS"), has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days. Instead, on June 3, 2022 (3 days prior to the hearing date), QRS requested a postponement and included its response therein. Specifically, QRS states that its failure to submit a listing of additional Medicaid eligible days is not due to the Provider abandoning the case but rather due "a significant issue with the State of North Carolina matching process and, more specifically, the voiding of certain Medicaid patient records from the State system." QRS represented that "[t]he Provider has been actively trying to work with the state to process eligibility" In this regard, QRS states:

> QRS has made the following efforts with the State:
>
> ***On July 28, 2020***, QRS requested for the eligibility listing to be sent directly to the MAC from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see [*sic*] if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee any updates to those older voided segments in the immediate future.
>
> ***On May 11, 2021***, QRS reached out to the State contact for an update to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is now a workable database but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.
>
> QRS continues to work with the State to develop an alternative method to fix the deficiencies. ***The last discussions took place in May and June of 2022.*** Once the system issues at the State are addressed, the match will be

[1] The correct time frame is 99 months since the appeal was filed.

> processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution. As such, QRS respectively requests for a postponement.
>
> 1. One final point is that on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013. As already noted, the MAC has challenged this appeal by taking the position that has not moved forward with the review process. Based on this challenge, the MAC does not agree with this postponement request. However, this challenge appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time.
>
> For the reasons discussed above, the Provider hereby request a 180-day postponement of case number 14-2767.

Board Analysis and Decision:

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

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

However, the Provider's appeal request does not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

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

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

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[2] Board Rule 25 (2018) gives the following instruction on the content of position papers:

Rule 25 Preliminary Position Papers

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline*.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

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

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

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

****

25.2 Position Paper Exhibits

[2] (Emphasis added.)

24.2.1 General

With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (*see* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

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

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

> **COMMENTARY:**
>
> The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.
>
> CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

Decision of the Board

The Board concurs with the Medicare Contractor that the Provider is required to provide documentation to prove the additional Medicaid Eligible days to which it may be entitled. Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[3] and, pursuant to 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25, the Provider has the burden to identify the number of days in dispute and present the supporting evidence (proving each day) as part of its position paper filing unless it adequately explains therein why such evidence is unavailable in compliance with Board Rule 25.2.2 (as issued by the Board pursuant to its authority under 42 C.F.R. §§ 405.1853(b)(3) and 405.1868(a)). In this regard, the Board notes that the Provider represented in its final position paper filed on March 6, 2021 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[4] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready.

The Board recognizes that, in its June 3, 2022 postponement request, QRS purports to *belatedly* provide information that it should have provided in its final position paper per Board Rule 25.2.2. Regardless of the untimely nature of this information, it is wholly inadequate and fatally flawed. In the postponement request, QRS now represents that, contrary to its representation in Carolinas' FPP that a listing had been completed, it had not yet been able to do a listing because, when it began trying to pull the data in July 2020, it experienced problems with the State. While QRS *represents* that it learned on July 28, 2020 that documentation was unavailable from the State Medicaid program, it failed to notify the Board or the opposing party in its final position paper as required by Board Rule 25.2.[5] Indeed, QRS did not even follow up with the State Medicaid Program until almost 10 months later on May 21, 2021 (more than 2 months ***after*** it had filed the Provider's final position paper). The Board again notes that, when Carolinas' FPP was filed on March 6, 2021, this appeal had been pending *for over 7 years* and the fiscal year at issue had been closed *for over 14 years*.

Further, there are multiple issues with QRS' *untimely* allegation that it has experienced problems obtaining supporting data from the State to identify ***any*** Medicaid eligible days at issue. First, neither QRS' extension letter nor the exhibit attached to it explain what the alleged State database problems are or when it began. Second, when the FFP was filed, it had been ***more than 11 years*** *since the close of Carolinas' FY 2009*. As a result, it is clear that neither Carolinas nor QRS were diligent in developing the merits of the 2008 Medicaid eligible days issue *by waiting* ***10+ years*** *until July 2020* to begin the process of identifying potential Medicaid eligible days to dispute for FY 2009.

[3] (Emphasis added).
[4] Final Position Paper at 11.
[5] In this regard, the Board notes that, as discussed *infra*, the July 28, 2020 email does not even relate to Carolinas or to 2008 but to another provider, Cape Fear for 2010. As a result, this could explain why it was not mentioned in Carolinas FPP, meaning that QRS had not actually begun work with the State on the Carolinas 2008 Medicaid eligible days issue.

Third, notwithstanding QRS' assertion in its postponement request, it is not clear that QRS began work with the State on the Carolinas' 2009 Medicaid eligible days issue. The email QRS includes to support its July 28, 2020 start date does not even relate to Carolinas but rather to another provider, Cape Fear for Cape Fear's FY 20**10** and a report run for Cape Fear 4 years prior, in 2016.[6] Accordingly, the Board questions whether QRS was even attempting to identify 200**9** Medicaid eligible days in dispute for Carolinas' FY 200**9** (which is another year entirely different from Cape Fear and for which QRS initiated work back in 2016).

Fourth, it is not clear what "problems" were being encountered with the State database and, given the fact that by July 2020, it had been more than 10 ½ years since the end of Carolinas' FY 2009, it is not surprising that the State data at issue was on an archived database as confirmed by the following excerpt from the July 28, 2020 email from the State:

> Are you talking about the Cape Fear report run back in 2016? I see one from April 1, 2016 and another one from May 26, 2006. I do still have those reports. Copying Carrina to see if this is something that she is able to approve. Also, *I don't see any updates to those **older voided** **segments*** anytime soon based on the response from the eligibility group.[7]

Accordingly, it is unclear. For example, by 2020, it is likely that the State had not maintained the 2009 data in its live database and that the issues being experienced were with an archived database. Had QRS or Carolinas been diligent in attempting to identify the Medicaid eligible days instead of waiting apparently 10+ years to begin to identify those days, would it have experienced the same problems? It is unclear from the record and, due to the excessive passage of time and lack of diligence, the Board must assume that the alleged "problems", if true, would *not* have been an issue.

Finally, the QRS' claim that, due to a moratorium on certain administrative resolutions ("ARs"), the Medicare Contractor may not enter into an AR for this case at this time on the Medicaid eligible days issue has nothing to do with the Provider's responsibility to develop the record. Moreover, even if the Medicare Contractor may not enter into an AR *at this time*, it does not prevent the Medicare Contractor from reviewing any submitted days listing, and finalizing that audit work and any resulting proposed adjustments in anticipation of a future AR in anticipation of the moratorium being lifted. Therefore, the inability to sign an administrative resolution, does not negate the fact that QRS has a responsibility to develop the merits of its case and that, notwithstanding that responsibility and the fact that this case has been pending now for 9+ years, it has been unresponsive to the MACs request for the Medicaid eligible days listings.

Based on the above, the Board finds that the Provider has failed to provide a Medicaid eligible days listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as

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[6] The July 28, 2010 email relates to another provider, Cape Fear, as noted by the reference to Cape Fear in the body of the email as well as the re: line entitled "Cape Fear 2010." Indeed, this email suggests that QRS began work on Cape Fear 4 years earlier back in 2016. In contrast, there is no evidence to suggest that QRS began to work with the State on Carolinas in either 2016 or in 2020 other than QRS' bald assertion.

[7] (Emphasis added.)

applicable via Board Rule 27.2). Nor has the Provider provided any *timely* explanation to the MAC[8] as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. Indeed, the Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[9] Accordingly, the Board must conclude that there are no days at issue and that the amount in controversy is $0.

As such, the Board hereby dismisses the DSH Medicaid Eligible Days issue from the appeal. As this was the last remaining issue in the appeal, the Board closes Case No. 14-2767 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:

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

For the Board:

4/14/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Dana Johnson, National Government Services

[8] As explained *supra*, the June 3, 2022 explanation is both untimely and fatally flawed.

[9] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Motion to Dismiss Medicaid Eligible Days***
Carolinas Medical Center (Prov. No. 34-0113)
FYE 12/31/2011
Case No. 15-2462

Dear Mr. Ravindran and Ms. Johnson,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 15-2462 in response to a Motion to Dismiss filed by the Medicare Contractor ("MAC"). The Board's is set forth below.

Background

Quality Reimbursement Services, Inc. ("QRS") is the Provider's designated representative for this appeal. On April 27, 2015, QRS established Case No. 15-2462 on behalf of the Provider by filing the Provider's Individual Appeal Request appealing their October 29, 2014, Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2011 ("FY 2011"). The initial appeal contained the eight (8) issue:

Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)[1]
Issue 2: DSH SSI Percentage (Systemic Errors)[2]
Issue 3: DSH Medicare Part C Days – SSI Fraction[3]
Issue 4: DSH Dual Eligible Days Exhausted Part A – SSI Fraction[4]
Issue 5: DSH Medicaid Eligible Days
Issue 6: DSH Medicare Part C Days – Medicaid Fraction[5]
Issue 7: DSH Dual Eligible Days Exhausted Part A – Medicaid Fraction[6]
Issue 8: Outlier Payments – Fixed Loss Threshold[7]

[1] The Board dismissed this issue in a Jurisdictional Decision on June 10, 2022.
[2] Issue 2 was transferred to Case No. 14-4265GC on December 30, 2015.
[3] Issue 3 was transferred to Case No. 14-4266GC on December 30, 2015.
[4] Issue 4 was transferred to Case No. 14-4267GC on December 30, 2015.
[5] Issue 6 was transferred to Case No. 14-4268GC on December 30, 2015.
[6] Issue 7 was transferred to Case No. 14-4269GC on December 30, 2015.
[7] Issue 8 was transferred to Case No. 15-1499GC on November 18, 2015.

The estimated impact of Issue 5 Medicaid eligible days for FY 2011 was 50 days for $19,077 without a listing of specific day in dispute.

In November and December 2015, the Provider transferred Issues 2, 3, 4, 6, 7, and 8 to common issue related party ("CIRP") groups as the Provider is part of a health chain and is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1).

On December 23, 2015, QRS filed the cover page to its preliminary position paper consistent with Board Rule 25 (July 1, 2015). Similarly, the Medicare Contractor filed the cover page to its preliminary position paper on April 11, 2016 consistent with that same rule.

On March 4, 2021, the Provider filed its final position paper. It did not indicate how many Medicaid eligible days were actually in dispute[8] and simply promised that "the Listing of Medicaid Eligible Days [was] being sent under separate cover."[9] Similarly, on April 1, 2021, the Medicare Contractor filed its final position paper.

On December 29, 2021, QRS filed a request for a 180-day postponement of the hearing stating "The Provider is *finalizing* a listing for submission to the MAC but is experiencing a delay in receiving an eligibility listing by the State."[10] On January 5, 2022, the Board rescheduled the hearing.

On May 23, 2022, the Medicare Contractor filed a Motion to Dismiss regarding Issue 5 – DSH Medicaid Eligible Days. On June 3, 2022, the Provider filed its response and requested another 180-day postponement request.

On June 3, 2022, QRS filed its response to the Medicare Contractor's Motion to Dismiss. QRS acknowledged that it had not submitted a listing of additional Medicaid eligible days being claims in this appeal but asserted that it had not abandoned the appeal because it was having difficulty in obtaining documentation from the state of North Carolina. QRS maintains that its difficulties in obtaining information from North Carolina warrant a postponement of this case.

On June 10, 2022, the Board issued a decision dismissing Issue 1. As a result of ensuing issue transfers and the Board's June 10, 2022 decision, only one issue remains in the case – Issue 5, Medicaid eligible days.

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[8] The final position paper included as Exhibit 2 a copy of the original *estimated* 50 days included in the "*estimated* reimbursement amount" listed on the issue statement for Issue 5 in the appeal request. (Emphasis added.) However, the final position paper did not reference or discuss that estimated amount but rather promised that an eligibility listing would be submitted under separate cover.

[9] Provider's Final Position Paper at 8. *See also* Exhibit 1 (stating that the Medicaid eligibility listing was "not included – being sent under separate cover").

[10] (Emphasis added.)

Medicare Contractor's Contentions[11]

On May 23, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 79[12] months since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.

Provider's Request for Postponement

On June 3, 2022 the Provider requested a postponement of the hearing and therein addressed the Medicare Contractor Motion to Dismiss by stating: "Although the Provider has indeed not submitted a listing of additional Medicaid Eligible days, this is not due to the Provider abandoning this case. Rather, there has been *a significant issue* with the State of North Carolina matching process and, more specifically, *the voiding of certain Medicaid patient records from the State system*. This issue has led to the Provider being unable to obtain an eligibility match listing which is needed to produce a listing of finalized days to the MAC. The Provider has been actively trying to work with the state to process eligibility which was mentioned in the previous postponement requests and communications with the MAC."[13]

In support of its contention, QRS describes the following efforts to obtain Medicaid eligible days relating to the Provider's FY 2011:

> ***On July 28, 2020***, *QRS requested for the eligibility listing to be sent directly to the MAC* from the respective state contact in the Business System Analyst department at the Information NC Department of Health and Human Services to see if the database used to process eligibility had been fixed. That same day, the contact in the Business System Analyst department informed QRS that, at that time, they did not foresee *any updates to* ***those older voided*** *segments* in the immediate future.

[11] The Board notes that the MAC filed a previous jurisdiction challenge on June 5, 2018, which included a challenge to the Medicaid eligible days issue which argued that the Board does not have jurisdiction over the issue because the MAC did not make an adjustment to the eligible days. This challenge was filed shortly after the issuance and CMS Ruling 1727-R and the Medicare Contractor did not raise these arguments in its more recent Motion to Dismiss.
[12] The correct time frame is 99 months since the appeal was filed.
[13] Provider's Request for Postponement (June 3, 2022) (emphasis added).

> ***On May 11, 2021***, QRS *reached out* to the State contact *for an update* to see if the database had been fixed and if the providers could obtain direct access to the match system. The analyst stated there is *now a workable database* but doubts the Providers have direct access to it. These match issues are system-wide and do not relate to any specific provider. Please see the attached email correspondence related to the State match issues.
>
> QRS continues to work with the State to develop an alternative method to fix the deficiencies. *The last discussions took place in May and June of 2022*. Once the system issues at the State are addressed, the match will be processed, and a listing prepared. QRS believes that the State system issues will ultimately be solved, and this appeal will be finalized through an administrative resolution.[14]

QRS ends by suggesting that the Medicare Contractor's opposition to QRS' postponement request "appears to be somewhat disingenuous as the MAC clearly does not have the authority to finalize an AR at this time" given that "on December 23, 2020 FSS was instructed not to implement Administrative Resolutions that impact DPP/DSH for cost reports prior to fiscal year end 2013."

Board Decision

According to its Appeal Request filed on April 27, 2015, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2011. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days,

[14] (Emphasis added.)

> unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[15]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

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

However, when QRS filed the April 27, 2015 appeal request, QRS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

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

> (b) *Position papers.* . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue**.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[16]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position

[15] Provider's Appeal Request (April 27, 2015).
[16] (Bold emphasis added.)

papers at Rule 25."[17] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline*.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, *state the material facts that support the provider's claim*.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> ****
>
> **25.2 Position Paper Exhibits**
>
> **24.2.1 General**
>
> With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (*see*

[17] (Emphasis added.)

42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to Board

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

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

> **COMMENTARY:**
>
> The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.
>
> CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,

- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On March 4, 2021, the Provider filed its final position paper in which it indicated that it would be sending the eligibility listing under separate cover.[18] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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

[18] Provider's Preliminary Position Paper (December 23, 2015).

> Base on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2010 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $19,077, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its final position paper or submitted such list under separate cover *even though this case has been pending for more 7 years*. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[19]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of § 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because QRS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days).[20] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[21] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its final position paper filed on March 6, 2021 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[22] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready.

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[19] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[20] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[21] (Emphasis added.)
[22] Final Position Paper at 11.

The Board recognizes that, in its June 3, 2022 postponement request, QRS purports to *belatedly* provide information that it should have provided in its final position paper per Board Rule 25.2.2. Regardless of the ***untimely*** nature of this information, it is wholly inadequate and fatally flawed. In the postponement request, QRS now represents that, contrary to its representation in Carolinas' FPP that a listing had been completed, it had not yet been able to do a listing because, when it began trying to pull the data in July 2020, it experienced problems with the State. While QRS *represents* that it learned on July 28, 2020 that documentation was unavailable from the State Medicaid program, it failed to notify the Board or the opposing party in its final position paper as required by Board Rule 25.2.[23] Indeed, QRS did not even follow up with the State Medicaid Program until almost 10 months later on May 21, 2021 (more than 2 months ***after*** it had filed the Provider's final position paper). The Board again notes that, when Carolinas' FPP was filed on March 4, 2021, this appeal had been pending *for almost six (6) years*.

Further, there are multiple issues with QRS' *untimely* allegation that it has experienced problems obtaining supporting data from the State to identify ***any*** Medicaid eligible days at issue. First, neither QRS' extension letter nor the exhibit attached to it explain what the alleged State database problems are or when it began. Second, when the FFP was filed, it had been ***more than 9 years*** *since the close of Carolinas' FY 2011*. As a result, it is clear that neither Carolinas nor QRS were diligent in developing the merits of the 2011 Medicaid eligible days issue *by waiting* ***9+ years*** *until July 2020* to begin the process of identifying potential Medicaid eligible days to dispute.

Third, notwithstanding QRS' assertion in its postponement request, it is not clear that QRS began work with the State on the Carolinas' 2011 Medicaid eligible days issue. The email QRS includes to support its July 28, 2020 start date does not even relate to Carolinas but rather to another provider, Cape Fear for Cape Fear's FY 20**10** and a report run for Cape Fear 4 years prior, in 2016.[24] Accordingly, the Board questions whether QRS was even attempting to identify 20**11** Medicaid eligible days in dispute for Carolinas' FY 200**8** (which is another year entirely different from Cape Fear and for which QRS initiated work back in 2016).

Fourth, it is not clear what "problems" were being encountered with the State database and, given the fact that by July 2020, it had been more than 9½ years since the end of Carolinas' FY 2011, it is not surprising that the State data at issue was on an archived database as confirmed by the following excerpt from the July 28, 2020 email from the State:

> Are you talking about the Cape Fear report run back in 2016? I see one from April 1, 2016 and another one from May 26, 2006. I do still have those reports. Copying Carrina to see if this is something

[23] In this regard, the Board notes that, as discussed *infra*, the July 28, 2020 email does not even relate to Carolinas or to 2008 but to another provider, Cape Fear for 2010. As a result, this could explain why it was not mentioned in Carolinas FPP, meaning that QRS had not actually begun work with the State on the Carolinas 2008 Medicaid eligible days issue.

[24] The July 28, 2010 email relates to another provider, Cape Fear, as noted by the reference to Cape Fear in the body of the email as well as the re: line entitled "Cape Fear 2010." Indeed, this email suggests that QRS began work on Cape Fear 4 years earlier back in 2016. In contrast, there is no evidence to suggest that QRS began to work with the State on Carolinas in either 2016 or in 2020 other than QRS' bald assertion.

> that she is able to approve. Also, *I don't see any updates to those* ***<u>older voided</u> segments*** anytime soon based on the response from the eligibility group.[25]

Accordingly, it is unclear. For example, by 2020, it is likely that the State had not maintained the 2011 data in its live database and that the issues being experienced were with an archived database. Had QRS or Carolinas been diligent in attempting to identify the Medicaid eligible days instead of waiting apparently 9+ years to begin to identify those days, would it have experienced the same problems? It is unclear from the record and, due to the excessive passage of time and lack of diligence, the Board must assume that the alleged "problems", if true, would *not* have been an issue.

Finally, the QRS' claim that, due to a moratorium on certain administrative resolutions ("ARs"), the Medicare Contractor may not enter into an AR for this case at this time on the Medicaid eligible days issue has nothing to do with the Provider's responsibility to develop the record. Moreover, even if the Medicare Contractor may not enter into an AR *at this time*, it does not prevent the Medicare Contractor from reviewing any submitted days listing, and finalizing that audit work and any resulting proposed adjustments in anticipation of a future AR in anticipation of the moratorium being lifted. Therefore, the inability to sign an administrative resolution, does not negate the fact that QRS has a responsibility to develop the merits of its case and that, notwithstanding that responsibility and the fact that this case has been pending now *for almost 8 years*, it has been unresponsive to the MACs request for the Medicaid eligible days listings.

****

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board hereby dismisses the Medicaid eligible days issue as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 27.2 and 25. Nor has the Provider provided any *timely* explanation to the MAC,[26] as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. Indeed, the record before the Board reflects ***no*** specific Medicaid eligible days in dispute ($0 in actual controversy) at this very late *post*-final position paper stage of the appeal. Further, the Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative and, notwithstanding, QRS failed to provide the Medicaid eligible days listing with its preliminary position paper.[27]

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[25] (Emphasis added.)

[26] As explained *supra*, the June 3, 2022 explanation is both untimely and fatally flawed.

[27] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by letter dated 5/5/2022); Case No. 16-2521 (by letter dated 5/5/2022); Case No. 16-0054 (by letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by letter dated 9/30/2022). Moreover, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor (as a motion or in a position paper) well in advance of the position paper filed in this case.

As no issues remain pending, the Board hereby closes Case No. 15-2462 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:

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

For the Board:

4/14/2023

X Clayton J. Nix

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

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

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RE: ***Board Decision – SSI Percentage (Provider Specific) and Medicaid Eligible Days***
Lake Norman Regional Medical Center (Prov. No. 34-0129)
FYE 09/30/2014
Case No. 18-0064

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 18-0064 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 18-0283

On October 13, 2017, Lake Norman Regional Medical Center, appealed a Notice of Program Reimbursement (NPR) dated April 26, 2017, for its fiscal year dating September 30, 2014 ("FY 2014"). The Provider appealed the following issues:[1]

- Issue 1: DSH SSI Percentage (Provider Specific/SSI Realignment)
- Issue 2: DSH SSI Percentage[2]
- Issue 3: DSH SSI Percentage - Medicare Managed Care Part C Days[3]
- Issue 4: DSH SSI Percentage - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Part A Days)[4]
- Issue 5: DSH – Medicaid Fraction – Medicare Managed Care Part C Days[5]
- Issue 6: DSH – Medicaid Fraction – Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Part A Days)[6]
- Issue 7: DSH - Medicaid Eligible Days

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Oct. 13, 2017).
[2] This issue was transferred to group case 17-0578GC.
[3] This issue was transferred to group case 17-0576GC.
[4] This issue was transferred to group case 17-0575GC.
[5] This issue was transferred to group case 17-0574GC.
[6] This issue was transferred to group case 17-0577GC.

- Issue 8: DSH - Medicare Managed Care Part C Days[7]
- Issue 9: DSH - Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days & No-Part A Days)[8]
- Issue 10: DSH - Uncompensated Care Distribution Pool[9]
- Issue 11: Two Midnight Census IPPS Payment Reduction[10]

As the Provider is commonly owned and, thereby, subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 5, 6, 8, 9, 10, and 11 to CIRP groups. As a result of these transfers, only two issues remain -- Issue 1 (the DSH SSI Percentage (Provider Specific) issue), and Issue 7 (the DSH – Medicaid Eligible Days issue).[11]

On April 10, 2018, the Medicare Contractor filed a Jurisdictional Challenge addressing a number of issues, including Issue 1, the DSH SSI Percentage (Provider Specific) issue, and Issue 7, DSH – Medicaid Eligible Days. This decision addresses the challenges of the two issues that remain pending in the appeal.

Significantly, the Provider did ***not*** file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

On August 24, 2022, the Board issued a Notice of Hearing requiring the Provider's final position paper to be filed by February 22, 2023 and the Medicare Contractor's final position paper to be filed by March 24, 2023.

Separately, on August 25, 2022, the Medicare Contractor filed a Final Request for Information, noting its previous attempts to acquire information regarding Medicaid Eligible days from the Provider, and the lack of any response.[12]

Finally, on January 3, the Medicare Contractor filed a 2nd final Request for Information due to the non-responsiveness of the Provider. The Provider neither responded to this request nor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0578GC

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

---

[7] This issue was transferred to group case 17-0574GC.
[8] This issue was transferred to group case 17-0577GC.
[9] The UCC issue was transferred to group case 17-0573GC, which was subsequently closed.
[10] This issue was transferred to group case 17-0572GC.
[11] MAC's Jurisdictional Challenge, at 1 (Apr. 10, 2018).
[12] MAC's Final Request for Information (Aug. 25, 2022).

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[13]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider was also directly added to the common issue related party ("CIRP") group under Case No. 17-0578GC entitled "QRS HMA 2014 DSH SSI Percentage CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[13] Provider's Request for Hearing, Issue Statement (Oct. 13, 2017).

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,
2. Failure to adhere to required notice and comment rulemaking procedures,
3. Fundamental problems in the SSI percentage calculation,
4. Not in agreement with provider's records,
5. Paid days vs. Eligible Days, and
6. Covered days vs. Total days.[14]

The amount in controversy for the Issue 1 is $26,000. This is the same amount that is listed as the amount in controversy for this Provider as a participant in Case No. 17-0578GC.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 17-0578GC, *QRS HMA 2014 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[15]

Lastly, Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.

Issue 7 – DSH – Medicaid Eligible Days

The MAC contends it did not make an adjustment to Medicaid eligible days as well as the provider did not self-disallow eligible days on their summary of protested items and therefore should be dismissed.

MAC's August 25, 2022 Final Request for Information

On August 25, 2022, the MAC filed its final request for the Medicaid eligible days listing and noted that, on August 25, 2022, the Board issued the notice of hearing for this appeal. The MAC asserts that the Provider would have first verified that additional days exist and verified as much through eligibility verifications. The MAC insists that the likelihood that eligibility determinations have yet to be made, *now 8 years later*, is zero and, thus, they would have expected to see a DSH package *with the filing of the appeal*. However, as the MAC has not received a DSH package, they formally requested one to resolve the Medicaid eligible day issue. If there are outstanding eligibility determinations, the Provider would be fully aware of which

[14] Group Issue Statement, Case No. 17-0578GC.
[15] MAC's Jurisdictional Challenge, at 2.

determinations had yet to be received.[16] Also, if information is not available, the MAC would require a response to the queries in the following list that is in accordance with PRRB Rules 7.3.1.2 and 25.2.2, on or before September 24, 2022. The MAC noted that it would expect a withdrawal of this appeal if the Provider does not submit a package which includes:

1. An electronic list (in Excel format) of Medicaid days included on the filed cost report or which was submitted for audit. For each patient record on the list, please include the patient's name, patient account number, date of admission and discharge, birth date, Social Security number, medical record number, Medicaid number, DRG, location of stay (PPS area, Rehab, SNF, Psych, Observation, Swing, etc.), days claimed per patient, and in total;
2. The electronic list (in Excel format) of the additional Medicaid days included in the appeal request. The list should include all necessary information as described in item 1 above;
3. Ensure all non-allowable days (including but not limited to: Dual eligible days, Medicare Part C days, general assistance days, unmet spend down days, duplicates days, etc.) are excluded from the list of additional days;
4. Documentation of Medicaid eligibility for each of the patients during their respective stays related to the additional days requested, in a searchable electronic format;
5. Documentation to support all additional days were related to a unit or ward of the hospital providing acute care services generally payable under the prospective payment system. This should also be submitted in a searchable electronic format;
6. If information is unavailable, please identify what information is unavailable, why the information has been unavailable up to this point, and document the efforts made to obtain the information.[17]

The MAC requested a response within 30 days of their letter.

On January 3, 2023, the MAC filed a renewed request for the eligible days listing and requested a response by February 3, 2023.

Provider's Response

The Provider did not file a response to the jurisdictional challenge. As previously noted, Board Rule 44.4.3 which specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Similarly, the Provider did ***not*** respond to the Medicare Contractor's requests for eligible days information filed on August 25, 2022 and January 3, 2023.

[16] MAC's Final Request for Information, at 1.
[17] *Id*. at 1-2.

Board Analysis and Decision

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

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly filed into Group Case No. 17-0578GC, QRS HMA 2014 DSH SSI Percentage CIRP Group.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 17-0578GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[18] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[19] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[20] The DSH systemic issues filed into Case No. 17-0578GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $26,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 17-0578GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

---

[18] Individual Appeal Request, Issue 1.
[19] *Id.*
[20] *Id.*

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 17-0578GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 17-0578GC.

Accordingly, *based on the record before it*,[22] the Board must find that Issues 1 and the group issue in Case No. 17-0578GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

B. DSH Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations. The Provider states Issue 7 as:

Statement of the Issue

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

[22] The Provider failed to respond to the jurisdictional challenge within the 30 days permitted (and still has not responded to date) and, per Board Rule 44.4.3, the Board will rule on jurisdiction challenges based on the record before it. Similarly, the Provider failed to file its final position paper by the February 22, 2023 deadline.

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[23]

The amount in controversy calculation and protested item documentation for this issue suggests the number of Medicaid eligible days at issue. However, the Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

While the Calculation Support filed with their appeal notes a net impact of $88,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.1.2 (Nov. 2021) states:

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

Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments

[23] *Id*.

and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[24]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe* ***to be decided by the Board*** *through a schedule applicable to a specific case or through general instructions*.[25]

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

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

Similarly, regarding position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;

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

3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.[28]

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [29] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Indeed, the Medicare Contractor has file 2 separate formal requests on August 25, 2022 and January 3, 2023 asking the Provider to send the Medicaid eligible days listing. However, the Provider failed to respond in any manner and also failed to file its final position paper on February 22, 2023. *Based on the record before the Board*, the Board

[28] (Emphasis added.)
[29] (Emphasis added.)

finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Accordingly, as the fiscal year at issue has been closed for 8+ years and this appeal has been pending for 5+ years and yet no Medicaid eligible days listing has been filed in this case, the Board must conclude that there are no actual Medicaid eligible days in dispute and that the actual amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[30] The Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 17-0578GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. The Board also dismisses the Medicaid Eligible days issue as the Provider also failed to meet the Board requirements for position papers and development of the merits for this issue as required by 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 18-0064 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:

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

For the Board:

4/14/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Greenbrier Valley Medical Center (Provider No. 51-0002)
FYE 04/30/2017
Case No. 21-0063

Dear Messrs. Ravindran and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. Quality Reimbursement Services, Inc. ("QRS") is the designated representative for the Provider and Federal Specialized Services is the designated representative for the Medicare Contractor. The decision of the Board is set forth below.

Background:

A. ***Procedural History for Case No. 21-0063***

On November 21, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2017. On May 1, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2 to a Common Issue Related Party ("CIRP") Group, Case No. 20-0997GC. The Provider also withdrew issues 4 and 5 from the appeal on April 30, 2021. The issues that remain pending in the appeal are DSH – SSI Percentage (Provider Specific) an DSH – Medicaid Eligible Days.

[1] On January 26, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on April 30, 2021.
[3] This issue was withdrawn on April 30, 2021.

On January 28, 2021, QRS filed the Provider's preliminary position paper.

On March 22, 2021, FSS filed the Medicare Contractor's Jurisdictional Challenge claiming that Issue 1 is a prohibited duplicate of Issue 2. The Provider did not file a response within the 30-day period allotted by Board Rule 44.4.3.

On June 4, 2021, FSS filed the Medicare Contractor's preliminary position paper.

On November 14, 2022, FSS filed the Medicare Contractor's Second Jurisdictional Challenge requesting dismissal of Issue 3 based on the fact that QRS had not filed or shared an eligible days listing.

On December 14, 2022, QRS timely filed its response to the Second Jurisdictional Challenge in compliance with Board Rule 44.4.3.

On December 28, 222, FSS filed the Medicare Contractor's Reply and Motion to Dismiss Issue 3. QRS did not respond to the Motion to Dismiss within the 30 day period allotted under Board Rule 44.3.

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

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

In the SSI percentage issue in CIRP group case 20-0997GC, which includes the Provider in this case, and the same fiscal year, the Providers assert that:

> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in

[4] Issue Statement at 1 (May 1, 2020).

> accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[5]

The amount in controversy for Provider No. 51-0002 in Case No. 20-0997GC is $19,000, the same amount as issue #1 in the individual appeal.

On January 28, 2021, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (April 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health* and Human Services, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published

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

> in the Federal Register on August 18, 2000. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $19,746. This is the same amount (rounded) that is listed as the amount in controversy for this Provider as a participant in 20-0997GC.

MAC's Jurisdictional Challenges

A. MAC's Contentions in its Jurisdictional Challenges

Issue 1 – DSH SSI Percentage (Provider Specific)

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

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

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI% - Systemic issue are considered the same issue by the Board.[8]

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[6] Provider's Preliminary Position Paper at 8-9 (Jan 28, 2021).
[7] Jurisdictional Challenge #1 at 6-7 (March 22, 2021).
[8] *Id*. at 4-6.

Issue 3 – Medicaid Eligible Days

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

> The MAC contends that the Provider was in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed. . .
>
> Within their preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[9]

Accordingly, the MAC requested that the Board dismiss the Medicaid eligible days issue.

B. Provider's Jurisdictional Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider did not file a response to this jurisdictional challenge.

Issue 5 – Medicaid Eligible Days

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[10] The Provider goes on to argue that:

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's

[9] Jurisdictional Challenge #2 at 4 (Nov. 14, 2022).
[10] Jurisdictional Response at 1 (Dec. 14, 2022).

> matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment.[11]

The Provider goes on to assert that "[c]oncurrent with this letter . . . the Provider[is] sending to the MAC the listing of additional Medicaid eligible days" and that "[a] redacted version of this listing is being posted to the Board's portal." Accordingly, the Providers assert that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[12] However, the Board notes that the Provider did not file the promised redacted listing of Medicaid eligible days or even identify how many Medicaid eligible days are actually in dispute.

Finally, the Provider generically states that its operations were disrupted by the COVID-19 pandemic and that it continues to face challenges related to COVID-19. However, the Provider did not explain how those challenges affected the development of the Medicaid eligible days issue or its position paper filing.

C. MAC's Reply & Motion to Dismiss Issue 3

On December 28, 2022, the Medicare Contractor replied to the Provider's response on Issue 1 and requested that the Board dismiss Issue 1. In filing the Motion, FSS stated that it "not requesting the Board deny jurisdiction due to Providers' failing to claim the Medicaid days at issue on each appeal's applicable cost report" but "[r]ather . . . is requesting the Board dismiss the issue due to each Provider's failure to file preliminary position papers in accordance with PRRB Rules, and effectively abandoning said issue." As a result, "[t]he Providers' claiming or not claiming the Medicaid eligible days on the applicable cost reports is not at issue in the MAC's request for dismissal."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

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[11] *Id*. at 2.
[12] *Id*.

1. First Aspect of Issue 1

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

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[14] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged

[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

"systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with 42 C.F.R. §405.1853(b)(2)-(3) and Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[18] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the*

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

hospital's fiscal year differs from the Federal fiscal year, for the ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

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

Accordingly, *based on the record before it,* the Board finds that Issue 1 in the instant appeal and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

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

B. Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

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

Statement of the Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[21]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[22] The Provider later argued that there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[23]

Board Rule 7.3.1.2 (Nov. 2021) states:

No Access to Data

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

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

[21] Individual Appeal Request, Issue 2.
[22] Provider's Preliminary Position Paper at 8 (Jan. 28, 2021).
[23] Jurisdictional Response at 1.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover.[24] The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[25]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[26]

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

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

Similarly, with regard to position papers,[27] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[28] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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[24] The fact that the Provider included as Exhibit 2, the "***estimated*** impact" of Issue 3 that was originally include with its appeal request has no relevance since it is an estimate based on an estimated "50" days and does not identify any specific days at issue and was not updated since the original appeal request include the "***estimated*** impact". At this state, the actual days at issue should be identified per 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25.

[25] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[26] (Emphasis added).

[27] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2.

[28] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[29]

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

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

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

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

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

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

[29] (Emphasis added).

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. The Provider is misplaced in believing it could file its listing with the final position paper since the Rules and regulations cited above regarding position papers were in effect well before August 29, 2018. Moreover, the Provider appears to be well aware of the August 29, 2018 revised rules since it complied with those changes and filed it complete preliminary position paper.

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[30] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The Provider's *untimely*[31] generic assertion in its December 14, 2022 filing that "practical impediments are preventing [it] from obtaining the necessary support" due to "the eligibility matching being unavailable ***at this time*** due to a change in the State's matching vendor changes"[32] is wholly inadequate and fatally flawed because:

1. It failed to explain why it failed to include this information as part of its preliminary position paper in compliance with Board Rule 25.2.2 and fails to explain why this information was not available at the time it filed its preliminary position paper. The fact that "at this time" (*i.e.*, as of December 14, 2022), it is not available does not mean that it was not available more than 3 years earlier when it filed its preliminary position paper in January 2021 when it promised one was being sent under separate cover. Indeed, it is unclear why the Provider has been unable to identify any actual Medicaid eligible days in dispute (whether that is one day or more).

2. Regardless, the statement fails to meet the requirements of Board Rule 25.2.2 since it did not describe its efforts to obtain the unavailable/missing documentation and when it would become available.

In summary, without any specific Medicaid eligible days identified in the position paper filing (or in the record even at this late date), the Board must conclude that there are no actual days in dispute and that the amount in controversy is, in fact, $0.

[30] (Emphasis added).
[31] Pursuant to Board Rule 25.2.2, the Provider was required to include this information as part of its position paper filing made almost a year earlier on January 28, 2021.
[32] (Emphasis added.)

Moreover, contrary to the Provider's assertion, the Provider has not attempted to cure this defect since the record still does *not* contain a listing of the Medicaid eligible days at issue.[33] Similarly, the Provider's reference to the COVID-19 pandemic is generic and it is unclear to what extent the Provider's filing of its preliminary position paper on January 28, 2021was impacted. More specifically, the Provider has failed to explain how its generic reference to the pandemic otherwise relates to its failure to comply with Board Rules and regulations and its development of the Medicaid eligible days issue. Again, this was something the Provider should have been including in its position paper filing per Board Rule 25.2.2 and not now almost a year later on a *post-hoc* basis.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[34]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue and failed to develop the merits of that issue in its position paper in compliance with 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-0063 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

4/14/2023

X Clayton J. Nix

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

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

[33] Note, the Board is *not* ruling that, had the provider done so, it would have accepted the listing at this late date. This situation is not before the Board and, as such, is not part of this ruling.
[34] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
D.M. Cogdell Memorial Hospital (Prov. No. 45-0073)
FYE 04/20/2015
Case No. 19-1694

Dear Messrs. Morris and Tisdale:

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in response to the Medicare Contractor's Preliminary Position Paper ("PPP"), which challenged the Board's jurisdiction, in the above-referenced appeal. The Board's decision is set forth below.

Background

The Board received the Provider's Appeal Request dated March 1, 2019, related to a Notice of Program Reimbursement ("NPR") dated September 7, 2018.[1] The Provider's Issue Statement included the following description of the Electronic Health Record ("EHR") Payment issue:

> The MAC's determination of EHR ineligibility for the Hospital's FYE 04/20/2015 Cost Report is inconsistent with the applicable statute, regulations and CMS instructions cited in the legal basis below. The MAC improperly removed all EHR data included on the Cost Report entry fields which resulted in the computation of a $0 EHR payment. As the Hospital did meet all requirements as an "EHR Meaningful User", it should be eligible for its EHR payment.[2]

Medicare Contractor's Position

In the Preliminary Position Paper filed on February 12, 2020, the MAC argues the Board lacks jurisdiction over the EHR issue. The MAC states in relevant part:

[1] Provider's Request for Appeal (March 1, 2019).
[2] Issue Statement at 2 (March 1, 2019).

> Aside from the merits of the issue argued above, the Provider runs afoul of the bar on administrative and judicial review found in 42 C.F.R. § 495.110. Depending on the outcome related to the MAC's inquiry and the Provider representative's pending response, the MAC may file a jurisdictional challenge and request the Board and ask for this case to be dismissed.[3]

Board Decision

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

The Board finds that it does not have jurisdiction over the EHR payment issue in the above-referenced appeal because jurisdiction is precluded by Section 1886(n) of the Social Security Act and 42 C.F.R. § 495.110(b). Here the Provider is appealing the Medicare Contractor's finding that it was not eligible for an EHR incentive payment and/or was not a meaningful user.

Section 1886(n) of the Act provides for incentives for adoption and meaningful use of certified EHR technology. Section 1886(n)(4)(A) states the following:

> **(4)Application.—**
>
> (A)Limitations On Review.— There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of-
>
> (i) the methodology and standards for determining payment amounts under this subsection and payment adjustments under subsection (b)(3)(B)(ix), including selection of periods under paragraph (2) for determining, and making estimates or using proxies of, discharges under paragraph (2)(C) and inpatient-bed days, hospital charges, charity charges, and Medicare share under paragraph (2)(D);
>
> (ii) the methodology and standards for determining a meaningful EHR user under paragraph (3), including selection of measures under paragraph (3)(B), specification of the means of demonstrating meaningful EHR use under paragraph (3)(C), and the hardship exception under subsection (b)(3)(B)(ix)(II); and
>
> (iii) the specification of EHR reporting periods under paragraph (6)(B) and the selection of the form of payment under paragraph (2)(F).

[3] MAC's Preliminary Position Paper at 9 (Feb. 12, 2020).

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

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

In the rulemaking process, the Secretary made clear that the Board does not have jurisdiction to hear appeals involving whether a provider is a meaningful user:

> Any issue involving incentive payment based upon a hospital cost report must be filed with the Provider Reimbursement and Review Board (PRRB); thus appeals raising hospital cost report issues will be dismissed in accordance with these proposed rules. However, we wish to make clear that *the PRRB would **not** have jurisdiction over issues to be decided under the administrative process described in this proposal (for example, **eligibility issues or whether a provider was a meaningful EHR user**)*.[4]

The Secretary finalized these appeal procedures in the final rule issued on September 12, 2012:

> We proposed to limit permissible appeals to the following three types of appeals:
>
> • Eligibility Appeals
> • Meaningful Use Appeals
> • Incentive Payment Appeals
>
> We also proposed certain filing and other deadlines for such administrative appeals. We refer readers to our proposed rule at (77 FR 13779 through 13780) for a full explanation of these proposals.
>
> We received several comments on our appeals proposals, which are discussed in this section of the preamble. However, after review of the public comments and the appeals filed as of the writing of this final rule, we believe the administrative review process is primarily procedural and does not need to be specified in

[4] 77 Fed. Reg. 13698, 13779 (Mar. 7, 2012) (emphasis added).

> regulation. The appeals process we proposed essentially constituted an agency reconsideration of certain types of determinations regarding eligibility for the program, meaningful use, or incentive payment amounts. We believe such an informal reconsideration process may be included in procedural guidance, rather than in our regulations. Therefore, our administrative appeals process will be included on our Web site at www.cms.gov/EHRIncentivePrograms.[5]

The appeals process outlined on the above website for eligibility and meaningful use appeals does not include the Board. Accordingly, The Board concludes that it does not have jurisdiction over the EHR issue in the above referenced appeal because judicial and administrative review of the calculation is barred by statute and regulation.[6]

As the instant case has no further issues, the Board dismisses Case No. 19-1694 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:

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Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/14/2023

X Clayton J. Nix

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

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

[5] 77 Fe. Reg. 53968, 54112 (Sept. 4, 2012).
[6] The Board recognizes that an adjustment was made on the cost report to change the Provider's answer to whether it was eligible for an EHR payment. However, there was no reimbursement impact because the EHR incentive payment process is handled outside the cost reporting process. This further reinforces the fact that there is no basis for an appeal of the EHR issue in this instance.

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RE: ***Decision to Rescind CMS Ruling CMS-1739-R Remand of Medicare Part C Days Groups***
Case No. 14-4266GC Carolinas Healthcare Sys. 2011 DSH SSI Fraction Part C Days CIRP Grp
Case No. 14-4268GC Carolinas Healthcare Sys. 2011 DSH Medicaid Fract. Part C Days CIRP

Dear Mr. Ravindran, Ms. Johnson and Ms. Flynn:

On August 10, 2022, the Provider Reimbursement Review Board (the "Board") remanded the above-captioned group appeals to the Medicare Contractor because it found the issue to be governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R. In reviewing a related case for one of the Providers included in the subject groups, the Board identified a previously-unknown jurisdictional impediment for Wilkes Regional Medical Center (Prov. No. 34-0064) for FYE 9/30/2011 as well as for both CIRP groups. A chronological listing of the pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **September 17, 2014**, Carolinas Healthcare System ("Carolinas") filed CY 2011 common issue related party ("CIRP") groups for the following issues:

Issue	Case No.
DSH SSI Baystate Errors	14-4265GC
DSH SSI Fraction Managed Care Part C Days	14-4266GC[1]
DSH SSI Fraction Dual Eligible Days	14-4267GC
DSH Medicaid Fraction Managed Care Part C Days	14-4268GC[2]
DSH Medicaid Fraction Dual Eligible Days	14-4269GC

[1] Case No. 14-4266GC was closed on August 10, 2022 via 1739R Remand of the Part C Days issue.
[2] Id.

On **April 8, 2015**, Quality Reimbursement Services, Inc. ("QRS") filed an individual appeal for Wilkes Regional Medical Center ("Wilkes") for FYE 9/30/2011.[3] Case No. 15-2162 included eight issues:

1) DSH SSI Provider Specific
2) DSH SSI Systemic
3) DSH SSI Fraction Managed Care Part C Days
4) DSH SSI Fraction Dual Eligible Days
5) DSH Medicaid Eligible Days
6) DSH Medicaid Fraction Managed Care Part C Days
7) DSH Medicaid Fraction Dual Eligible Days
8) Outlier Payment Fixed Loss Threshold

On **July 20, 2015**, QRS filed the following CY 2011 ***optional*** groups, and on November 4, 2015 requested the transfer of Wilkes for the respective issues from Case No. 15-2162:

Issue	Case No.
DSH Medicaid Fraction Dual Eligible Days	15-3031G[4]
DSH SSI Fraction Managed Care Part C Days	15-3032G
DSH SSI Systemic	15-3037G
DSH Medicaid Fraction Managed Care Part C Days	15-3038G
DSH SSI Fraction Dual Eligible Days	15-3039G[5]
Outlier Payment Fixed Loss Threshold	15-3040G[6]

On **November 25, 2015**, Carolinas filed five Transfer Requests for Wilkes to transfer five of the *same* issues from Case No. 15-2162 to the following CIRP groups (even though QRS had previously transferred those issues to *optional* groups):

Issue	Case No.
DSH Medicaid Fraction Dual Eligible Days	14-4269GC
DSH SSI Fraction Managed Care Part C Days	14-4266GC[7]
DSH SSI Systemic	14-4265GC
DSH Medicaid Fraction Managed Care Part C Days	14-4268GC[8]
DSH SSI Fraction Dual Eligible Days	14-4267GC

[3] The representative letter included with Case No. 15-2162 was dated August 28, 2013 and was signed by Ronal Costanzo, VP of Corporate Reimbursement for the Carolina HealthCare System. It authorized QRS to be the representative for the Provider in the context of the individual case as well as any related group appeals.
[4] Case No. 15-3031G was dismissed in the Board's June 10, 2022 "Deferring Show Cause Order & Closure of Cases.
[5] Id.
[6] On November 19, 2015, QRS rescinded the transfer of the Outlier issue to Case No. 15-3040G and requested that it be transferred to the CIRP group for the same issue that had been filed by Carolinas under Case No. 15-1499GC. Case No. 15-3040G was subsequently withdrawn and closed on July 16, 2019.
[7] Case No. 14-4266GC was closed on August 10, 2022 via 1739R Remand of the Part C Days issue.
[8] Id.

On **February 1, 2019**, QRS filed a request for expedited judicial review ("EJR") in eight Medicare Managed Care Part C Days *optional* groups, including the *optional* groups under Case Nos. 15-3032G and 15-3038G in which it included Wilkes on the Schedule of Providers ("SoP"). In a letter dated **February 28, 2019**, the Board requested additional information because it found the general reference to the "2004 Rule" as the legal authority being challenged, to be too vague. Consequently, to satisfy the EJR requirements, the Board required the EJR request to be resubmitted, specifically identifying the particular preamble language being challenged with cite references to the Federal Register and an explanation as to how that language was binding on the Board.

On **March 14, 2019**, in accordance with the Board's request, QRS filed a Revised EJR request. The Revised EJR request for Case Nos. 15-3032G and 15-3038G continued to list Wilkes as a participant on the SoPs.

On **April 8, 2019** the Board issued its EJR determination in Case Nos. 14-4266GC and 14-4268GC, finding that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1). Both groups were closed as a result of the EJR.[9] Again, Wilkes is listed as a participant in the SoPs for Case Nos. 15-3032G and 15-3038G that were attached to the EJR decision.

On **August 10, 2022**, the Board remanded the 2011 Part C Days issue for Carolinas in Case Nos. 14-4266GC and 14-4268GC pursuant to CMS Ruling 1739-R and closed both CIRP group cases. Wilkes is also listed on the SoPs for Case Nos. 14-4266GC and 14-4268GC attached to the remand decision.

Board Determination:

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

42 U.S.C. § 1395oo(f)(1) specifies, in pertinent part that "Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** *be brought by such providers as a group* with respect to any matter involving an issue common to such providers."[10] The Secretary implemented this statutory requirement in the regulation at 42 C.F.R. § 405.1837(b)(1) which requires that commonly owned or controlled providers file CIRP group appeals for each common issue of fact, law or rulings occurring in the same year. *See also* Board Rules 12 and 13 regarding the formation of group appeals (https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB- Instructions.html).

[9] Wilkes Regional Medical Center was listed as participant #26 on the Schedules of Providers for both Case Nos. 15-3032G and 15-3038G included with the EJR determination.
[10] (Emphasis added.)

Further, Board Rule 4.6.1 bars a provider from being a participant in more than one appeal for the same issue, from the same determination. In fact, the Certification page of the group appeal request includes a statement that the Representative certifies ". . . the group issue filed . . . is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn or dismissed from any other PRRB appeal."[11]

The Board is bound by the statutes and regulations, including those governing CIRPs, specifically 42 C.F.R. § 405.1837(b)(1)(i) which requires that commonly owned or controlled providers file single groups for the same issue occurring in the same year. Accordingly, for purposes of Wilkes Regional Medical Center and its CY 2011 issues, the Provider can be a participant in ***only*** *one group for each common issue.* Accordingly, the Board hereby **dismisses** Wilkes from the group.

Moreover*,* because Wilkes was and is commonly owned by Carolinas*,* it is clear that Wilkes was required to pursue that common Part C Days issue as part of a CIRP group, *to the extent other Carolinas providers wished to pursue the* ***same*** *issue for the* ***same*** *year*. However, Wilkes pursued the common Part C Days issue as part of the optional appeal groups under Case Nos. 15-3032G and 15-3038G and, as part of those groups, was granted EJR by letter dated April 9, 2019[12] to pursue the group issue in federal court. Therefore, consistent with 42 U.S.C. § 1395oo(f)(2) and 42 C.F.R. §§ 405.1837(b)(1) and (e)(1), the Board finds that the participation of Wilkes Regional Medical Center in the optional groups, Case Nos. 15-3032G and 15-3038G (which are now closed), precluded Carolinas from pursuing the ***same*** Part C Days issues for the ***same*** year in the Carolinas HealthCare CIRP groups, under Case Nos. 14-4266GC and 14-4268GC. In other words, pursuant to these authorities, Wilkes Regional Medical Center's participation in the *optional* groups results in the forfeiture of any right of the related Carolinas providers to pursue the ***same*** issue for the ***same*** year in these CIRP groups. Based on this additional information, the Board hereby **reopens** and **rescinds** the August 10, 2022 Remand issued pursuant to CMS Ruling 1739-R in Case Nos. 14-4266GC and 14-4268GC and **dismisses** both group appeals. In making this rescission and dismissal, the Board notes that the three-year period to reopen the April 9, 2019 EJR determination for the *optional* groups under Case Nos. 15-3032G and 15-3038G has now passed and, as such, any potential other remedial action is foreclosed.

The Board ***reprimands*** ***QRS*** in its handling of Wilkes and its apparent failure to properly consult and coordinate with Carolinas to ensure Wilkes' compliance with the mandatory CIRP group requirements. In this regard, the Board notes that the appeal request that QRS filed on behalf of Wilkes specifically recognized that Wilkes is commonly owned by Carolinas, and thus is subject to the mandatory CIRP group rules.

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

[12] The Board's April 9, 2019 EJR determination pertains to Case Nos. 15-3032G and 15-3038G as well as 5 other *optional* group cases (Case Nos. 15-2388G, 16-1143G, 16-1144G, 17-1410G, and 17-1411G). The EJR determination lists Wilkes for FY 2011 as participant 26 in the Schedule of Providers for Case Nos. 15-3032G and 15-3038G attached thereto.

Similarly, the Board ***reprimands*** ***Carolinas*** for its apparent failure to monitor and manage its representative QRS which it appointed to handle the Wilkes individual appeal and its failure to ensure that it complied with the mandatory CIRP group rules.

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. The Board will address the participation of Wilkes Regional Medical Center in the SSI Percentage and Dual Eligible Days group cases under separate cover.

Board Members Participating:

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

For the Board:

4/21/2023

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Danelle Decker, National Government Services (J-K) (MAC for optional groups)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Dismissal of Delnor Community Hospital*** (Prov. No. 14-0211), FYE 8/31/2018
as a participant in Case No. 22-0054GC:
Northwestern Medicine CY 2018 Understatement of PPS Standardized Amount CIRP Group

Dear Mr. Gienko and Ms.VanArsdale:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") group in response to a March 20, 2023 jurisdictional challenge filed by the Appeals Support Contractor's ("ASC's), Federal Specialized Services ("FSS"). The pertinent facts and the Board's determination are set forth below.

Background:

On October 20, 2021, Strategic Reimbursement Group, LLC ("Strategic" or "Representative") filed the a CIRP group appeal entitled the "Northwestern Medicine CY 2018 Understatement of PPS Standardized Amount CIRP Group" under Case No. 22-0054GC.

On January 21, 2022, Strategic added Delnor Community Hospital ("Delnor") to the group from receipt of its Notice of Program Reimbursement ("NPR") dated July 13, 2021.[1]

On March 20, 2023, FSS filed a jurisdictional challenge requesting the dismissal of Delnor from the group. FSS contends that the direct addition of Delnor to the group was untimely filed from receipt of its NPR in violation of 42 C.F.R. § 405.1835(a)(3) and Board Rules.[2]

[1] The date of Delnor's NPR entered in the Office of Hearings Case & Document Management System ("OH CDMS") was **July 31,** 2021 rather than **July 13,** 2021. Using the transposed date, the direct add for Delnor appeared to be timely filed.

[2] To date, Strategic has not responded to the ASC's jurisdictional challenge which was due by April 19, 2023, although on April 4, 2023, Strategic did file a response to the FSS' Substantive Claim challenge for two other group participants.

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

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. In this case, the Medicare Contractor issued Delnor's NPR on July 13, 2021. The 185th day fell on Friday January 14, 2022. The Direct Add for Delnor was not filed until January 21, 2023, which was 192 days after the issuance of the final determination.[3]

Therefore, the Board finds that the direct add of Delnor to Case No. 22-0054GC does not meet the regulatory filing requirements and hereby dismisses Delnor from the group. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(F) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case.

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

For the Board:

4/25/2023

X Ratina Kelly

Ratina Kelly
Board Member
Signed by: Ratina S. Kelly -S

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

[3] "Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination. . . ". There was no allegation of good cause filed with Delnor's direct add filing.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Baystate Medical Center (Prov. No. 22-0077)
FYE 09/30/2006
Case No. 16-1960

Dear Ms. Webster:

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

On March 31, 2023, the Provider filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue for FYE 2006.[1] The initial request for hearing originated on January 14, 2013, after the Provider's request to join the Southwest Consulting BH 2006 DSH SSI Group, Case No. 08-2921GC from its revised Notice of Program Reimbursement ("NPR") dated July 20, 20212. The Provider included an issue statement along with the Direct Add request. In a letter dated June 2, 2016, the Board notified the Provider the issue statement presented a *different* issue than the group issue in Case No 08-2921GC, and asked if a separate CIRP group should be formed for this provider, or if an individual appeal should be set up. On June 29, 2016, the Provider responded asking for an individual appeal to be established. Accordingly, consistent with 42 C.F.R. § 405.1837(e)(4), on July 11, 2016, the Board established Case No. 16-1960, including with it the original issue statement that was submitted with the direct add.

The Provider's original issue statement that was used to establish the instant appeal was presented as a single issue. However the Provider notes in its Preliminary Position Paper (as

[1] Petition for Expedited Judicial Review (Mar. 31, 2023).

confirmed by the MAC's Preliminary Position Paper) that there are two distinct issues under appeal in this case. In the request for EJR, the Provider requests that the Board update the OH CDMS record to reflect the two distinct issues in this individual provider appeal, and to note that the Provider is *only* requesting expedited judicial review for the first part of this issue.

Upon review of the issue statement in this individual provider appeal, the Board agrees that the issue statement encompasses the following two separate issues:

1. Whether the Medicare Part A/SSI fraction is understated because patients who where enrolled in a plan under Part C of Medicare were included in the fraction; and

2. Whether the Medicare Part A/SSI fraction is understated due to systemic errors and deficiencies in the data and process used to calculate that fraction.

As a result, the Board is updating OH CDMS to reflect these two separate issues – Issues 1 and 2. Further, the Board's decision to **grant** the Provider's request for EJR of Issue 1 in part *and* to **deny** it in part is set forth below.

Statutory and Regulatory Background

A. Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[2] stated that:

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

[2] of Health and Human Services.

> Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[6]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[7]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[8] In response to a comment regarding this change, the Secretary explained that:

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[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction.*
>
> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[9]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[10] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[11] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH

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[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *Id*. at 47411.
[12] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).

policy adopted in FFY 2005 IPPS rule.[14] In *Allina Health Services v. Price* ("*Allina II*")*,*[15] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[16] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

B. CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these

[14] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.
[21] *Id*.

> consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[22]

Provider's Request for EJR

In Issue 1, the Provider is challenging their Medicare reimbursement for the fiscal year 2006 cost reporting period. The Provider states that it "has been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Provider further asserts that, despite the federal court rulings in these cases, their respective DSH payment determination remains "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Provider argues that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Provider concludes that the Board is "required" to grant EJR.[26]

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[22] CMS Ruling 1739-R at 6-7.
[23] Providers' Petition for Expedited Judicial Review, at 1, PRRB Case no. 16-1960.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.

The Provider argues that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Provider disagrees with CMS' instruction to the Board to remand this appeal, and argues that a remand is counter to the provider's right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Provider concludes that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Provider also argues that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's

[27] *Id*. at 11-12.
[28] *Id*. at 22.
[29] *Id*. at 13.
[30] *Id*. at 13-14.

> attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Decision and Analysis

As discussed above, the Provider has requested EJR over Issue 1 in its individual appeal. After review of the Provider's EJR request, the Board has determined that the EJR request over Issue 1 contains two separate and distinct issues for the Board to consider.

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

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

A. Board's Authority

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

The Board's analysis is detailed below.

B. Jurisdictional Requirements for Provider

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for the Provider requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

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[31] *Id.* at 16-17.
[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

The Provider in this case *timely* filed from a revised NPR determination involving fiscal year 2006 as a direct add to a group appeal and, following denial of that direct-add request, the Board established this individual appeal consistent with 42 C.F.R. § 405.1837(e)(4). For any Provider that files from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor "specifically revised" within the revised NPR.[34] The Board notes that the revised NPR in this appeal was issued *after* August 21, 2008 (on July 20, 2012).

Upon review of the jurisdictional documentation, the revised NPR at issue had adjustments to the SSI percentage which included revisions to the Part C days, as required for jurisdiction under the provisions of 42 C.F.R. § 405.1889. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[35] and that the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount. Accordingly, the Board finds that it has jurisdiction for the referenced appeal and the provider.

C. Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[36] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[37] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[38] To date, CMS has yet to issue its new final rule.[39]

As the Provider's appeal concerns the FY 2006 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the provider's Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny provider's EJR request concerning the Medicare Part C Days issue.

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[34] *See* 42 C.F.R. § 405.1889(b)(1) (2008).
[35] *See* 42 C.F.R. § 405.1837.
[36] (Emphasis added.)
[37] CMS Ruling 1739-R at 1-2.
[38] Id. at 2.
[39] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[40] Accordingly, the Board will issue, under separate cover, a remand with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

D. Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C appeal at issue here. . . . [T]he Provider has submitted supporting documentation that establishes its satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this *via* the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[41]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[42] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority

[40] (Emphasis added.)
[41] EJR Request at 16-17 (emphasis in original).
[42] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[43]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [44] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[45]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[46] Here, the Provider essentially challenges the Board's *application* of the CMS Ruling 1739-R. Specifically, the Provider challenges the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeal within the instant appeal, under 1739-R. There are no days being appealed *after* October 1, 2013;

2) The Board hereby recognizes that there are two distinct issues, as noted in the Preliminary Position Papers, and bifurcates the original issue into the two distinct issues noted earlier: the Part C Days issue, and the SSI Systemic Errors issue, for DOCD purposes within OH CDMS;

3) The Board hereby **denies** Provider's EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather,

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[43] *See Southwest* at 6-7.
[44] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[45] *See* CMS 1739-R at 8.
[46] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

pursuant to CMS 1739-R, the Provider will receive a remand letter of this issue under separate cover, for the applicable days; and

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

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal. Case No. 16-1960 remains open for the sole remaining issue – Issue 2 concerning the DSH SSI fraction.

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For the Board:

4/25/2023

X Clayton J. Nix

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

cc: Wilson Leong, FSS
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RE: ***Board Decision – Jurisdictional Challenge***
The Medical Center Beaver (Prov. No. 39-0036)
FYE 06/30/2014
Case No. 17-2214

Dear Messrs. Randall and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-2214, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

The Provider's Notice of Program Reimbursement ("NPR") for its fiscal year end ("FYE") 6/30/2014 was issued on March 23, 2017. The Provider's Request for appeal was timely filed with the Board on September 11, 2017 with four issues:

- Issue 1 – DSH State Only and Title XXI (General Assistance Days);
- Issue 2 – DSH – Medicaid Eligible Days;
- Issue 3 – DSH SSI Percentage
- Issue 4 – DSH – Uncompensated Care[1]

On April 10, 2018, the MAC filed a jurisdictional challenge, challenging the Board's jurisdiction over Issues 1, 2, and 4.

Issue 4 is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[2] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit

[1] Request for Hearing, at Tab 3, Issue Statement (Sep. 11, 2017).
[2] Request for Hearing, at Tab 3, Issue Statement (Sep. 11, 2017).

meaningful commentary on the proposed rules.[3] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[4] decision. They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[5]

On April 14, 2023, the Board sent an inquiry whether a jurisdictional decision on "the Medicaid ratios issues" was still necessary for the referenced appeal. The MAC responded regarding Issues 1 and 2, "the Medicaid ratios issues," and confirmed that the jurisdictional challenge to "the Medicaid ratios issues" is no longer relevant, and a Board decision was not necessary, thus withdrawing the challenges to Issues 1 and 2. The MAC also indicated that it continues to challenge jurisdiction for issue 4, DSH – Uncompensated Care.[6]

Accordingly, the Board's decision here only addresses the jurisdictional challenge relating to Issue 4, the DSH – Uncompensated Care issue.

MAC's Contentions

Issue 4 – DSH – Uncompensated Care

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

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

Provider's Response

For the Uncompensated Care issue, the Provider argues that it does not request the Board to review the Secretary's uncompensated care calculation. Rather the Provider requests the Board to review the provider's adjustment to add to the total DSH payment comprised of the Empirically Justified portion and the Uncompensated Care portion to account for data that CMS

[3] *Id*.
[4] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[5] Request for Hearing, at Tab 3, Issue Statement.
[6] MAC's Response to Board's JC Decision Inquiry (Apr. 24, 2023).
[7] MAC's Jurisdictional Challenge, at 8.
[8] *Id*.

may have excluded. The Provider had furnished its explanation for the additional $97,121 in its appeal documentation sent to the Board:

> In the Final Rule published in the Federal Register (FR Vol.79, No. 163, p 50011) CMS *presumed* an increase in DSH of 4.9% and 3.4% respectively for FY 2014 and FY 2015. CMS based this on an *assumed* Medicare expansion of 32% and that 50% of the newly expanded Medicaid enrollees are a healthier population as determined by their actuarial. No support has been published indicating that the expansion population 'are healthier than the average Medicaid recipient' or for the calculation of the assumed increase percentages. The healthy assumption adjustment continues as indicated in the FY 2015 - FY 2017 Final Rules. The Hospital has used an estimated dollar amount of 5% of the DSH amount resulting in an estimated reimbursement impact of this issue of approximately $97,121.[9]

The Provider adds that that the 5% is FY 2014 DSH increase of 4.9% rounded. The 5% is applied to the total DSH & Uncompensated Payments of $1,942,421.79 resulting from the application of the MAC's audit adjustments #6 & #7. Because the Provider's additional 5% adjustment is not a Secretary's uncompensated care calculation, the it concludes that the Board then has jurisdiction over this issue.

Board Analysis and Decision

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

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

1. *Bar on Administrative Review*

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

[9] Provider's Response to MAC's Jurisdictional Challenge, at 3 (May 1, 2018).

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[10]

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

2. Interpretation of Bar on Administrative Review

a) Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[11] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[12] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[13] 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.[14]

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.[15]

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[10] 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.
[11] 830 F.3d 515 (D.C. Cir. 2016).
[12] 89 F. Supp. 3d 121 (D.D.C. 2015).
[13] 830 F.3d 515, 517.
[14] *Id.* at 519.
[15] *Id.* at 521-22.

b) DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[16] 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."[17] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[18]

c) Scranton Quincy Hosp. Co. v. Azar

In *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[19] 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.[20] 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.[21] 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.[22] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[23]

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

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[16] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[17] *Id.* at 506.
[18] *Id.* at 507.
[19] 514 F. Supp. 249 (D.D.C. 2021).
[20] *Id.* at 255-56.
[21] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[22] *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.
[23] *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.[24]

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."[25] 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.[26] 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.[27]

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.[28] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d) Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[29] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[30] Ultimately, the D.C. Circuit found that 42 U.S.C.

[24] *Id.* at 262-64.
[25] *Id.* at 265.
[26] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[27] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[28] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[29] 61 F. 4th 999 (D.D.C. 2023).
[30] *Id*. at 1002.

§ 1395ww(r)(3) bars administrative and judicial review of the providers' claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar*.[31]

The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[32] finding that [t]he audit protocol neither alters the Hospitals' substantive obligations nor changes the DSH payment calculation scheme" but rather "[i]t only sets the procedures by which the Secertary will determine the third factor of the uncompensated care payment, without altering the substance of the DSH calculation scheme or other related legal standards."[33] Accordingly, the D.C. Circuit affirmed the district court's grant of summary judgement to the Secretary finding that the Secretary's S-10 audit protocol "does not constitute a "rule" or "requirement" that changes a *substantive legal standard*, but is a statement of policy regarding the Secretary's procedural methodology."[34]

The Board finds that the same findings are applicable to the Provider's challenge to their FYE 6/30/2014 UCC payments. The Provider here is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* 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.[35]

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In summary, the Board hereby dismisses Issue 4, DSH Uncompensated Care, as it is precluded from appeal by statute. As there are issues still pending in the appeal, the case will remain open.

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[31] *Id.* at 1003-04.
[32] 139 S. Ct. 1804 (2019).
[33] *Ascension* at 1003.
[34] *Id.* at 1003.
[35] 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).

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

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For the Board:

4/28/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services