DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC.
360 W Butterfield Road, Suite 310
Elmhurst, Illinois 60126

RE: ***Board Decision***
SRG Summa 2012-2013 Medicaid Eligible Medicare Unmatched Days CIRP Group
Case Number: 16-1883GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Administrative Contractor's ("MAC") Jurisdictional Challenge. The Board's analysis and determination is set forth below.

Background:

On June 9, 2016, the Provider Group Representative, Strategic Reimbursement Group LLC, filed a request for hearing. The Initial Appeal contained two (2) Providers: Summa Barberton Citizens Hospital (Provider Number 36-0019) and Summa Health System (Provider Number 36-0020). The Providers' Group Issue Statement reads:

> Medicaid Eligible Medicare Unmatched Days:
>
> The Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Provider's Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations").
>
> The Provider contends that these days have been incorrectly identified as Medicare days and that they are not included in the Medicare Fraction (or SSI ratio) of the DSH calculation as indicated by CMS. Provider requests that the necessary files be provided to review the Medicare Fraction and determine if the omitted days were or were not included in the Medicare Fraction. The Provider requests any days omitted from their Calculations on the premise that these days were in fact included in the Medicare

> Fraction, but as a result of review were identified to have not been included in the Medicare Fraction, be instead properly included in the hospital's Calculations in order to correct the Calculations to be consistent with statute 42 U.S.C. 1395ww(d)(5)(F)(vi)(II).[1]

On January 3, 2017, Summa Barberton Hospital (Provider No. 36-0019) FY 2013 was added to the group appeal. The Group was fully formed on August 3, 2023.

On August 4, 2023, the Board issued a CIRP Group Fully Formed and Critical Due Dates Notice ("Critical Due Dates Notice"). Significantly, the Critical Due Dates notice set the deadline for the Provider's preliminary position paper as October 3, 2023, and included the following instruction on that filing:

> "Group's Preliminary Position Paper – 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 Group 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."

On September 15, 2023, the Provider filed its Preliminary Position Paper with two Federal Register sections as exhibits. On January 8, 2024, the Medicare Contractor filed its Preliminary Position Paper.

On January 2, 2024, the Medicare Contractor filed a Jurisdictional Challenge, and the Providers did not file a response.

Medicare Contractor's Contentions:

The Medicare Contractor filed the Motion to Dismiss on November 30, 2023 and argues that 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.[2] The Medicare Contractor states that the documentation needed to determine the days in dispute was provided to the provider for both fiscal years in dispute, at least six years before the preliminary paper was submitted.[3] Therefore the Medicare Contractor requests that the Board consider the issue as abandoned as the Providers have had "adequate time to develop the merits of their appeal."[4]

[1] Group Issue Statement (June 9, 2016)
[2] Medicare Contractor's Motion to Dismiss at 4-5 (January 2, 2024).
[3] *Id.* at 2.
[4] *Id.* at 4-5.

Providers' Jurisdictional Response:

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

Board Analysis and Decision:

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

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.[5]

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

Board Rule 25 (v 3.1) gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**

[5] (Bold emphasis added.)

The text of the position papers must include the elements addressed in the applicable subsection.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For **each** issue that has not been fully resolved, provide a **fully** developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

Rule 25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (*see* 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted documents

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

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 or filing deadlines (*see* 42 C.F.R. § 405.1868);
>
> - if the Board is unable to contact the provider or representative at the last known address, or
>
> - upon failure to appear for a scheduled hearing.

According to its Appeal Request filed on June 9, 2016, the Providers challenge the "exclusion of days pertaining to patients with Medicaid coverage and … contend[s] that these days have been incorrectly identified as Medicare days and that they are not included in the Medicare Fraction (or SSI ratio) of the DSH calculation as indicated by CMS."[6] On September 15, 2023, the Provider filed its Preliminary Position Paper. The Preliminary Position Paper asserts that the "provider has requested the necessary MedPAR SSI Data Files and is performing a review to identify Medicaid days incorrectly omitted from the Medicaid Fraction of their Calculations. The detailed listing will be provided forthcoming."[7]

The Medicare Contractor's Jurisdictional Challenge suggests that the Providers did not meet the requirements set forth in the regulations and PRRB Rules and have not developed its preliminary position paper with all the relevant facts and arguments to support its appeal. The Medicare Contractor maintains the "Providers have requested and obtained their MedPAR data for FYE 12/31/2012 and FYE 12/31/2013 cost report on multiple occasions."[8] The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to

[6] Providers' Group Issue Statement (June 9, 2016).
[7] Providers' Preliminary Position Paper at 6.
[8] Medicare Contractor Jurisdictional Challenge at 2.

prove its Medicaid Eligible Medicare Unmatched Days, 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 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of its Medicaid Eligible Medicare Unmatched Days. The Provider representative had the opportunity to respond to the Motion to Dismiss and failed to do so. Accordingly, the Board hereby dismisses the Medicaid Eligible Medicare Unmatched Days issue as being abandoned.

Decision

The Board hereby dismisses the appeal in its entirety as the Provider failed to meet the Board requirements for position papers for this issue, in compliance with 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 16-1883GC 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:

4/1/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

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

Via Electronic Delivery

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

Scott Berends, Esq.
Federal Specialized Services
1701 South Racine Ave.
Chicago, IL 60608

RE: ***Recission of Dismissal & Closure of Group Appeals Per 42 C.F.R. § 405.1842(h)(3)(iii)***[1]
Group A Cases – Case Nos. 17-0808GC, *et al.*
Group B Cases – Case Nos. 19-2458GC, *et al.* (*see* listing marked as Appendix A)

Dear Messrs. Ravindran and Berends:

As the parties are aware, James Ravindran of Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed *consolidated* requests for expedited judicial review ("EJR") for certain Baylor Scott & White Health ("BSW") common issue related party ("CIRP") groups. Specifically, QRS filed the following consolidated EJR requests:

1. On June 10, 2022, a consolidated EJR request for the four (4) BSW CIRPs identified as the Group A Cases in **Appendix A** (with 66 participants in aggregate); and

2. On June 8, 2022, a *consolidated* EJR request for the two (2) BSW CIRP groups identified as Group B Cases in **Appendix A** (with 32 participants in aggregate).

As discussed in further detail *infra*, QRS ***belatedly*** *notified the Board on August 31, 2022* that, in connection with both the Group A and B Cases, it had filed a complaint almost 2 months earlier, on June 10, 2022, in the U.S. District Court for the District of Columbia ("D.C. District Court"),[2] and significantly, the June 10, 2022 filing of this Complaint occurred ***concurrent with the filing of the consolidated EJR requests for the Group A and B Cases*** (on June 10, 2022 and June 8, 2022 respectively).[3]

On **June 29, 2022**, the Board issued a Scheduling Order ("Scheduling Order") in each of the Group A and B Cases. The Scheduling Order noted that the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*")[4] ***after*** QRS filed the instant EJR request.

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[1] In review of its docket, the Board has identified these cases that are similar to other QRS cases involving the same type of closure circumstances triggered by 42 C.F.R. § 405.1842(h)(3)(iii) as needing to be closed but, unfortunately, were not closed earlier. *See also infra* notes 43-45 and accompanying text discussing the 642 group cases involving 2000+ participants that were filed during this time period and the complex procedural history surrounding that concentrated volume of EJR requests. *See also* **Appendix C**.

[2] *Baylor Univ. Med. Ctr. v. Becerra*, Case No. 1:22-cv-01678 (D.D.C. filed June 10, 2022).

[3] The Board notes that the *consolidated* EJR requests for the Group A Cases was filed with the Board at 5:07 pm EDT and, as such, it would appear likely that the June 10, 2022 Complaint as it relates to the Group A Cases was filed with the D.C. District Court ***prior to*** the EJR request being filed.

[4] 142 S. Ct. 2354 (2022) (issued on June 24, 2022).

Since the *Empire* decision was directly relevant to the issues in the EJR Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue a Scheduling Order requiring QRS to file a response within 21 days (*i.e.*, by Wednesday July 20, 2022):

1. Giving updates on whether the participants of *each* group were still pursuing the merits of the *consolidated* EJR Request;
2. Requesting withdrawals for each case not being pursued; and
3. Updating or clarifying, as relevant, the EJR request to discuss the impact of *Empire* on the *consolidated* EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[5]

The Scheduling Order also notified the parties that "the 30-day period for responding to the EJR requests has not yet commenced for these [4] CIRP group appeals and will not commence until the Board completes its jurisdictional review of the these CIRP groups."[6] As part of its detailed explanation, the Board noted that "in implementing 42 U.S.C. § 1395oo(f)(1), the Secretary has made clear at 42 C.F.R. § 405.1842 that the 30-day period 'does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.'"[7] *Following the Board's Scheduling Order, QRS filed* ***no objections*** *or requests for clarification with regard to the Scheduling Order itself.* As a result, the Board and FSS continued to take actions consistent with the Scheduling Order. The Medicare Contractors were required to file, through FSS, any response to QRS' response no later than 21 days after it was filed.

On **July 20, 2022**, QRS *timely* filed the Providers' response in the Group A and B Cases to the Scheduling Order. It noted that the Providers in all of the CIRP group cases remained committed to pursuing the consolidated EJR request and that none would be withdrawn. It recognized that "the Empire decision [held] that exhausted days are properly includable in the Medicare fraction and . . . that 'entitled' and 'eligible' have the same meaning for purposes of the Medicare fraction."[8] In light of the *Empire* decision, QRS then stated that it "intend[ed] to submit an ***updated*** EJR Requests to focus on the numerator of the Medicare Fraction, insofar as only 'paid' days are included there, and not also 'eligible' (a/k/a 'entitled' days)."[9] As a result, QRS "request[ed] an additional 14 days in which to submit their updated EJR requests."[10] Again, QRS' response did *not* include any objection to the Board's notice that the 30-day period to review an EJR request had not begun, *nor* did it notify the Board of the lawsuit it had already filed roughly 1½ months earlier on June 10, 2022.)

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[5] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (*see* 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii).
[6] Board letter dated June 29, 2022 for Group A and B Cases at 1.
[7] *Id.* at 3 (quoting 42 C.F.R. 405.1842(b)(2) (emphasis added)).
[8] QRS letter dated July 20, 2022 at 2.
[9] *Id*. (emphasis added).
[10] *Id.*

On **August 2, 2022**, QRS filed a letter noting that the Board had not yet ruled on or replied to QRS' July 20, 2022 response to the Board's June 29, 2022 Scheduling Order and requested that the Board grant an extension on the July 20, 2022 deadline for the Group A and B Cases similar to some *unrelated* cases involving another health chain – University of Arizona Health (which have a lead case of Case No. 15-1161GC). Specifically, QRS requested an extension to August 22, 2022.

On **August 3, 2022**, the Board issued a Denial of EJR Requests and Scheduling Order in both the Group A and B Cases. It noted that QRS' July 20, 2022 response was, at best, incomplete and sought additional time to brief *Empire* along with a new issue focusing on "paid days" included in the numerator of the Medicare Fraction. The Board found that QRS failed to brief the *Empire* decision as required by the Board's Scheduling Order and denied the request for additional time to do so, noting that QRS waited until the ***final*** day to request an extension to file its response to the Board's RFI. Accordingly, the Board:

1. Denied the originally-filed *consolidated* EJR Requests for all of the Group A and B Cases because: (a) a group may contain only one issue pursuant to 42 C.F.R. § 405.1837(a); (b) "it is clear from the response that, due to the Supreme Court's decision in *Empire*, the Providers are ***not*** pursuing the invalidation of the Secretary policy to count no-pay Part A days in the Medicare fraction as adopted in the FY 2005 IPPS Final Rule (the "No-Pay Part A Policy") and, through that invalidation seeking to have no pay Part A days excluded from the Medicare fraction and, to the extent those days involve dually eligible patients, included in the numerator of the Medicaid fraction"; and (c) instead, "QRS has represented that there is a ***new*** *and separate issue* in these CIRP groups involving only the numerator of the Medicare fraction."[11]

2. Dismissed the No-Pay Part A Days issue from Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases "since it is clear that [as a result of *Empire*,] QRS is not pursuing the No-Pay Part A Policy (and failed to otherwise timely brief that issue per the Board's [June 29, 2022] RFI."

3. Dismissed Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases since these cases only relate to the *Medicaid* fraction and could not relate to the alleged new issue since the new issue clearly only pertains to the numerator of the DSH Medicare fraction.

For the remaining open cases (*i.e.*, Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases), the Board noted that QRS needed to request bifurcation in order to pursue any new issues no later than September 1, 2022. It noted that any bifurcation requests would need to include: (i) the original group issue statement with an explanation of how the new issue was included therein; (ii) an explanation of how any new issues had not been abandoned in filings made in each CIRP group case; (iii) an explanation of how each amount in controversy calculation contemplated the issue decided in *Empire* and any newly sought issues; and (iv) for participants who were transferred from individual appeals, an explanation of how it included any newly sought issues in its original appeal request.

[11] (Emphasis added.)

Following the Board's Order for Additional Briefing, QRS did not file any objections or requests for clarification with regard to the Order itself. As a result, the Board and FSS continued to take actions consistent with that Order. The Medicare Contractors were required to file, through FSS, any reply to the Group Representative's response no later than September 30, 2022.

On **August 31, 2022**, for both the Group A and B Cases, QRS timely filed its response to the Board's August 3, 2022 Scheduling Order. Within its response, QRS obliquely notified the Board that it had commenced an action in federal court and served the Secretary of Health and Human Services on August 18, 2022 and attached a copy of the Complaint filed on June 10, 2022 to initiate that lawsuit. At this late date, QRS then insisted that "the Board does not possess jurisdiction over these cases *because they have been* ***filed*** *in federal court* [on June 10, 2022]"[12] and, as a result, the Board now lacked jurisdiction to dismiss or take any action in these cases as a result of its federal court filing. Nevertheless, without legal analysis[13] or reference to the original group appeal request (or other jurisdictional documents) underlying each of these group appeal, QRS ***summarily*** argued that the Providers in [the Group A and B Cases] . . . appeal an "***alternate issue***, *i.e.,* whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction."[14]

Accordingly, QRS has *represented* that it filed litigation to pursue the Group A and B Cases more than eighty (80) days *prior to its August 31, 2022 notice to the Board* and, more egregiously, *concurrent with* ***the filing of the consolidated EJR requests for the Group A and B Cases***.[15] Specifically, on June 10, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the *yet-to-come* EJR and jurisdictional review process by filing a complaint in the D.C. District Court under Case No. 1:22-cv-01678 seeking judicial review on the merits of its EJR Request in the Group A and B Cases (filed June 10, 2022 and June 8, 2022 respectively).[16] Through operation of 42 C.F.R. § 405.1842(h)(3)(iii), which states: "If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved[]," the Board could conduct no further proceedings in the Group A Cases and Group B cases upon the filing of the Complaint. Thus, the fact that QRS filed a federal district court complaint ***concurrent*** with its filing of the *consolidated* EJR request for the Group A and B Cases[17] demonstrates that QRS had *no intention* of allowing the Board to process its EJR requests for those cases, pursuant to 42 U.S.C. § 1395oo(f)(1)

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[12] QRS letter dated Aug. 31, 2022 at 2.

[13] Legal analysis would include reference to each provider's right to appeal whether under 42 C.F.R. §§ 405.1835(a), (c) or 405.1837(a) and the content requirements for those appeal requests under 42 C.F.R. §§ 405.1835(b), (d) or 405.1837(c) as relevant. For example, the Board notes that § 405.1835(c) states that a group appeal request "***must*** *include* all of the following . . . . (3) . . . *a* ***precise*** *description of the* ***one*** ***question*** of . . . ***interpretation of law***, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal." (Emphasis added.)

[14] Note 42 C.F.R. § 405.1837(a) specifies that a group can only pertain to "a single question of . . . interpretation of law, regulations or CMS Rulings that is common to each provider in the group." Similarly, 42 C.F.R. § 405.1837(f)(1) specifies that "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider may not add other questions of fact or law to the appeal, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart)."

[15] *See supra* note 2.

[16] Case No. 1:22-cv-01678 also includes other appeals and providers which have been addressed under separate cover.

[17] *See supra* note 2.

and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to ***immediately*** notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board in the Group A and B Cases.

QRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix C**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, pursuant to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board to] respond[] to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states, in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 (Nov. 2021) states, in pertinent part:

> Board jurisdiction must be established **prior to** granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue **prior to** granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** *it determines whether it has jurisdiction and the request for EJR is complete*. *See* 42 C.F.R. § 405.1842.[18]

Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to

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

the Scheduling Orders issued in these cases, and in fact requested *additional* time to comply and participate with the Board's June 29, 2022 Scheduling Order.

QRS made clear by filing the Complaint (*i.e*., "the lawsuit"[19]) in federal district court on June 10, 2022, that it was bypassing and abandoning the Board's prerequisite jurisdictional review process and processing of the EJR request within the time allotted under 42 U.S.C. § 1395oo(f)(1) as implemented by the Secretary at 42 C.F.R. § 405.1842.

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. For example, how is the Court to know that, *subsequent to QRS filing the lawsuit to pursue the merits of the Group A and B Cases*, QRS stated its intention to file a new EJR request and that the Board: (1) denied the original *consolidated* EJR request for the Group A and B Cases; (2) dismissed the no-pay Part A days issue from Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases; and (3) dismissed Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases? Did it similarly withdraw this participant from the federal litigation being pursued? To further illustrate this very point, the Board has included at **Appendix B**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a federal lawsuit *prior to filing the Consolidated EJR requests* in connection with the Group A and B Cases.

A. The 30-day Period For the Board to Respond to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR, pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1), which states in relevant part:

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to

[19] 42 C.F.R. § 405.1842(h)(3)(iii) ("*If* ***the lawsuit is filed*** *before a final EJR decision is issued on the legal question*, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved." (emphasis added)).

> decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[20]

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal <u>if there is Board jurisdiction to conduct a hearing on the matter</u>** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
>
> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.

[20] (Emphasis added.)

> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.
>
> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[21]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[22] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[23]

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[21] (Emphasis added).

[22] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).

[23] (Emphasis added.)

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) in the appeals underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[24] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[25] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[26]

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[24] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[25] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[26] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[27] Not only are the federal trial courts ill-suited for making such determinations, but it is a task assigned to the Board, *by statute*.

Significantly, in the Group A and B Cases,[28] the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. First, on August 3, 2022, before completing its jurisdictional review, the Board (1) denied the *consolidated* EJR request for both the Group A and B Cases; (2) dismissed the no-pay Part A days issue from Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases as being abandoned; and (3) dismissed Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases because QRS' July 20, 2022 filings made it clear that they were not pursuing the DSH Medicaid fraction issue in those groups since QRS made clear it was only pursuing an "alternate issue" involving the DSH Medicare or SSI fraction. With respect to the remaining open groups (*i.e.*, Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases), the Board stopped its jurisdictional review process after it learned that QRS had bypassed the completion of this process even before 30-days had elapsed. Having sufficient time to complete the jurisdictional and substantive claim review[29] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in the Group A and B Cases as highlighted in **Appendix B**.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin

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[27] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on June 3, 2022***, QRS continued to expand the record and take actions in the Board proceedings in these group cases (*e.g.*, indicating in its July 19, 2022 correspondence with the Board that an updated EJR Request would be filed based on the Supreme Court's *Empire* decision) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

[28] As discuss *supra*, on August 3, 2022, the Board dismissed Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases and, to the extent those cases were remanded for reinstatement, then the Board would similarly need to complete the jurisdictional review process in these 3 cases.

[29] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

until the Board completes its jurisdictional review process *and* finds jurisdiction.[30] QRS' filing of the Complaint in federal district court ***concurrent with <u>its filing of the EJR Request</u>***, without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request in the Group A and B CIRP group cases.

B. Effect of QRS' <u>Concurrent</u> Filing of the Complaint on the Group A and B Cases

The regulation at 42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits, relating to an EJR request, affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may <u>not</u> conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[31]

Thus, once "the lawsuit is filed," this regulation ***bars any further Board proceedings*** relating to the *consolidated* EJR request filed in the Group A and B Cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. As a result, the following rulings taken by the Board in its August 3, 2022 determination were void in the first instance and the Board hereby rescinds those rulings in recognition of that fact: (1) denial of the *consolidated* EJR request for the Group A and B Cases; (2) dismissal of the no-pay Part A issue from Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases; and (3) the dismissal of Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases. Further, consistent with FRCP 62.1, the Board is deferring any further action in the Group A and B Cases until, or if, the Administrator remands these cases back to the Board.

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[30] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al v. Xavier Becerra*, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).

[31] (Emphasis added.)

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[32] and the May 23, 2008 final rule[33] which promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[34]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should

[32] 69 Fed. Reg. 35716 (June 25, 2004).
[33] 73 Fed. Reg. 30190 (May 23, 2008).
[34] 69 Fed. Reg. at 35732.

> attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[35]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' *concurrent* filing of the Complaint in the D.C. District Court on June 10, 2022 prohibited the Board from conducting any further proceedings on the consolidated EJR request for the Group A and B Cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements. As such, the Board's issuance of the August 3, 2022 determination was void in the first instance and is hereby rescinded in recognition of that fact.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation to pursue the merits of the Group A and B Cases is tantamount to bad faith, and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided by 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[36] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

> **1.3 Good Faith Expectations**
>
> 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.

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[35] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

[36] The recent changes to the Rules (effective Nov. 1, 2021) were first published on June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), QRS, as the Providers' designated representative, is responsible for: (1) being familiar with, and following, Board rules and procedures and the governing regulations (including 42 C.F.R. § 405.1842(b)(2)); and (2) timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[37]

Indeed, the following acts (or inaction) by QRS reinforces the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS failed to notify the Board that it had filed a lawsuit on June 10, 2022 to pursue the merits of the Group A and B Cases *concurrent with its* filing of the *consolidated* EJR requests for the Group A and B Cases (June 10, 2022 and June 8, 2022 respectively), notwithstanding the fact that the EJR process is the only procedural process that allows the groups to bypass the Board's administrative review process.

[37] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling that the 30-day period to review the EJR request had not yet begun, and the associated Scheduling Orders for the Group A and B Cases reaffirming that ruling. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[38] It also resulted in the Board issuing its August 3, 2022 determination in error, because, had the Board known that a lawsuit had already been filed concurrent with the filing of the *consolidated* EJR requests for the Group A and B Cases, it would not have issued that determination consistent with 42 C.F.R. § 405.1842(h)(3)(iii).

3. QRS can make no claims that it was harmed by any delay caused by the Board's Scheduling Orders notifying QRS that the 30-day period to process the EJR request had not yet begun due to additional time needed for the Board to complete its jurisdictional review when QRS filed a federal district court case ***concurrent with its filing of the EJR requests for the Group A and B Cases.***

4. The Board made known to the parties in the Group A and B Cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2).[39] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its initial Scheduling Order on June 29, 2022 for the Group A and B Cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day period to review the EJR request and then reaffirmed that ruling in subsequent Scheduling Orders. QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its

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[38] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make known to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Corp. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule, it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

[39] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

rulings and, if necessary, correct or clarify them,[40] or take other actions, ***prior to*** QRS filing its June 10, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow initiation of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges the Board missed in its federal litigation)***, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[41]

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the D.C. District Court for the Group A and B Cases violates Board Rule 1.3, and caused both the Board and the Medicare Contractors to waste time and administrative resources when the Board was prohibited from taking any further action on the Group A and B Cases appeals, pursuant to 42 C.F.R. § 405.1842(h)(3)(iii).

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, June 10, 2022, prejudiced the Board, FSS and the Medicare Contractors. Specifically, it hijacked the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to cease work on the Group A and B Cases in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the D.C. District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue.[42] The prejudicial sandbagging is highlighted by the facts that:

1. During the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges caused by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

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[40] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 20-26 and accompanying text.

[41] *See supra* note 38 (discussing how the FRCP supports the Board's position).

[42] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[43]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix C**, a copy of the closure letter it issued in 80 QRS cases that were included in a February 14, 2022 Federal Complaint in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that: (1) QRS and HRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering 178 cases with 969 participants and did so without completing the jurisdictional review process, much less receiving the Board's jurisdictional decision, and without notice to the Board;[44] and (2) QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509.[45]

It is clear the Providers are pursuing the merits of their cases in the Group A and B Cases as part of their lawsuit in the D.C. District Court.[46] Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[47]

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded back for further proceedings*, the Board may, as relevant and appropriate, reinstate its August 3, 2022 determination and/or complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[48]

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[43] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS, *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filed by QRS has been filed both in federal district courts for California and the District of Columbia. *See infra* notes 44 and 45 and accompanying text; **Appendix C**.

[44] Under separate cover, the Board closed the QRS cases by letters dated September 30, 2022 (Grouping A for Case Nos. 13-3842GC, *et al.*; Grouping B for Case Nos. 17-2150GC, *et al.*; and Grouping C for Case Nos. 18-0037GC, *et al.*), and the HRS cases dated October 19, 2022 (Grouping A for Case Nos. 14-2400GC, *et al.*; and Grouping B for Case Nos. 15-055G, *et al.*). These closure letters included similar findings as in these QRS group cases.

[45] The Board addressed the cases impacted by this litigation under separate cover.

[46] This is notwithstanding the Board's dismissal of 3 of these group cases.

[47] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[48] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix C**.

Examples of available remedial actions that the Board may consider taking in the Group A and B Cases to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the Group A Cases and/or Group B Cases and all underlying participants.

2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.

3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[49] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****

[49] 42 C.F.R. § 405.1868 states:

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

(Emphasis added.)

> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[50]

Pursuant to the above, the Board has broad authority to sanction QRS for its repeated, and ongoing, malfeasance.

E. Board Decision and Order

Based on QRS' misconduct, the Board hereby takes the following actions:

1. Consistent with 42 C.F.R. § 405.1842(h)(3)(iii), rescinds the Board's August 3, 2022 determination denying the EJR request; dismissing the no-pay Part A days issue from Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases; and dismissing Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases because, on June 7, 2022, "the lawsuit [wa]s filed before a final EJR decision [wa]s issued on the legal question, [thus] the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved" and, accordingly, the Board's June 22, 2022 determination was void in the first instance.

2. Consistent with 42 C.F.R. § 405.1842(h)(3)(iii), closes the groups under Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases which remained open, and affirms that the groups under Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases remain closed;

3. Suspends the ongoing jurisdictional review process for the Group A and B Cases; and

4. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[51]

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[50] 73 Fed. Reg. at 30225.

[51] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

Accordingly, the Board hereby closes the Group A and B Cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

4/3/2024

X Clayton J. Nix

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

Enclosures:

Appendix A – Case List
Appendix B – Interim List of Potential Jurisdictional & Procedural Violations Under Review for the Group A and B Cases
Appendix C -- June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: John Bloom, Noridian Healthcare Solutions (JF)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

APPENDIX A

List of the Group A and Group B Cases

GROUP A CASES—Covered by Consolidated EJR Request dated June 10, 2022 and the Board's August 3, 2022 EJR denial and dismissal determination that the Board is now rescinding:

17-0808GC – QRS BSWH 2014 DSH Medicaid Fract. Dual Elig. Days (Late Issuance of NPR) CIRP Grp.
17-0811GC – QRS BSWH 2014 DSH SSI Fraction Dual Elig. Days (Late Issuance of NPR) CIRP Grp.
18-1280GC – QRS BSWH 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group
18-1281GC – QRS BSWH 2015 DSH SSI Fraction Dual Eligible Days CIRP Group

GROUP B CASES—Covered by Consolidated EJR Request dated June 8, 2022 and the Board's August 3, 2022 EJR denial and dismissal determination that the Board is now rescinding:

19-2458GC – BS&W Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2460GC – BS&W Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX B

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW RELATIVE TO THE GROUP A AND B CASES[52]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process *relative to both the Group A and B Cases*.[53] This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving multiple group cases and when many of those cases are older cases (7+ years old).

Through its ongoing review of jurisdiction and other procedural issues in the Group A and B Cases, the Board has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board notes that: (1) in dismissing Case Nos. 17-0808GC and 18-1280GC in the Group A Cases and Case No. 19-2460GC in the Group B Cases, the Board had not yet completed its jurisdictional review process and that process would still be ongoing upon the recission of the Board's August 3, 2022 determination; and (2) the Board has not completed its jurisdictional review process in Case Nos. 17-0811GC and 18-1281GC in the Group A Cases and Case No. 19-2458GC in the Group B Cases, due to QRS' August 31, 2022 notice of the lawsuit.

The Board's review is based on the Schedules of Providers ("SoPs") filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[54] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) for the Group B Cases include, but are not limited to, the following:

1. *Invalid Appeals Due to Failure to Timely Appeal or Provide the Requisite Documentation*.— QRS failed to include sufficient documentation in the SoPs to establish that some of the participants filed timely appeals. As a result, the Board is reviewing dismissal of several of the participants for failure to meet the claims filing requirements.

2. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in the Group B Cases arrived by transfer from an individual provider appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[55] The Board expects

[52] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 36 group cases.

[53] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[54] *See also* Board Rule 20.1 (Aug. 2018).

[55] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a

it may identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

3. *Failure to Document Compliance with the Minimum Amount in Controversy ("AiC") for a Group Appeal*.— As explained in 42 C.F.R. § 405.1839(b): "[i]n order to satisfy the amount in controversy ["AiC"] requirement . . . for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."[56] Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ."

4. *Open Procedural Issues in the Group A and B Cases Following the Supreme Court's Decision in Empire*.—On the June 29, 2022, the Board ordered QRS to confirm whether it was still pursuing each of the Group A and B Cases notwithstanding the Supreme Court's decision in *Empire* and for each case being pursued:

> [U]pdate[] (or clarify[y], as relevant) the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction (and excluding the subset of days involving dually eligible patients from the numerator of the Medicaid fraction).[57]

The footnote attached to the above quote included reminders that "a group appeal may only contain **one** issue in order for the Board to have ***jurisdiction*** over the group"[58] and that "group member are not allowed to aggregate claims involvinig different issues for purposes of satisfying the minimum $50,000 amount in controversy requirement."[59] The Board has not yet had an opportunity to review QRS' response.

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provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

[56] Consistent with 42 C.F.R. § 405.1840(a), Board Rule 6.3 (2013) requires that "*[f]or each issue*, provide a calculation or support demonstrating the amount in controversy." (Emphasis added.)

[57] (Footnote omitted.)

[58] Board's June 29, 2022 letter at n.20 (emphasis in original) (cross-referencing n.13 stating: "The Board further notes that, in order to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue. *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board.").")

[59] *Id.* at n.20 (cross-referencing n.14 stating: "42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840. *See also* 42 C.F.R. § 405.1839(b) (stating in paragraph (2) that "[f]or purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues" and that "[a] group appeal must involve a single

QRS' August 31, 2022 letter responding to the Board August 3, 2022 Scheduling Order raises issues for the both Group A and B Cases. In that letter, QRS asserts that "with the proceedings in *Empire Health Foundation* in mind, and to respond directly to the Board's inquiry, the Providers in the captioned cases **likewise appeal** the alternate issue, *i.e.*, of whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction. The Providers' complaint filed in the D.C. District Court includes allegations, and request for relief, regarding the alternate issue." It appears that QRS has either added to its appeal an alternate issue or that its original group appeals for the Group A and B Cases encompassed more than one issue notwithstanding the following regulatory requirements:

(1) 42 C.F.R. § 405.1837(a)(2) requiring that "[t]he matter at issue in the group appeal involves a ***single*** *question of . . .* ***interpretation*** of law, regulations, or CMS Rulings that is common to each provider in the group";[60]

(2) 42 C.F.R. § 405.1837(c)(3) requiring that each group appeal request include "a ***precise*** *description of the one question of . . .* ***interpretation*** of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal";[61] and

(3) 42 C.F.R. § 405.1837(a)(3) requiring that "[t]he amount in controversy [for a group appeal] is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart" which, in particular, requires at 42 C.F.R. § 405.1839(b)(2)(i), that "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** *allowed to aggregate claims involving* ***different issues*** . . . . [since a] A group appeal must involve a ***single*** question of . . . ***interpretation*** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart)."[62]

In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue and the group appeal must document that it meets the amount in controversy for that one issue.[63] The Board is reviewing the Group A and B Cases to determine whether, as asserted

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question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart)")."

[60] (Emphasis added.)

[61] (Emphasis added.)

[62] (Emphasis added.)

[63] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bold emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.

in the August 31, 2022 QRS letter, the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[64]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[65]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[66] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[67] and, as relevant, whether it requested transfer of those additional issues to the group and documented a separate amount in controversy for the alleged additional issue; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[68]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2) ***at this late stage*** *of the appeal when* ***all*** *jurisdictional documentation is* ***already*** *required to be part of the record*. A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years. As noted, the Board flagged this issue in its August 3, 2022 letter, and it was in the QRS' response to this inquiry that the Board learned of the litigation that QRS filed bypassing completion of the Board's administrative review process. *Indeed, to the extent,* ***the Group A and B Cases*** *are remanded back to the Board and the QRS makes similar claims regarding an* "*alternative issue*," ***the Board would also need to conduct this same jurisdictional inquiry to determine the scope of the Group A and B Cases and whether ERJ would continue to be appropriate given the subsequent legal development of the Supreme Court's Empire decision***.[69]

(A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

[64] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[65] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[66] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.

[67] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.

[68] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Cases where the Providers' preliminary position paper was filed prior to the relevant consolidated EJR request being filed include: Case Nos. 21-0237G, 21-0273G and 21-0239G where the position paper was filed in January 2022.

[69] The Borad notes that the Board found the consolidated EJR determination to be limited to the "legal questions of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid; and, if not, what policy should then apply which, per the 9th Circuit decision in *Empire* but contrary to the Provider's position, is the Secretary's policy in effect prior to the FY 2005 IPPS Final Rule that excluded no-pay Part A days from the Medicare fraction and (to the Provider's dissatisfaction) also excluded those days from the numerator of the Medicaid fraction in situations involving a dual eligible." Note each of these legal questions was specified and pursued in a separate and district CIRP group where each provider participated in 2 separate CIPR groups for each year where one CIRP group covered one legal question and the other CIRP group covered the other legal question.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the June 10, filing of the Complaint in federal district court ***concurrent with its filing of the consolidated EJR requests for the Group A and B Cases*** (June 10, 2022 and June 8, 2022 respectively), that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above) as it relates to both the Group A and B Cases.

APPENDIX C

June 10, 2022 Board Letter to QRS
Deferring Show Cause Order and Closure of Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to QRS Filing in California Central District Court

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Scott Berends, Esq.
Federal Specialized Services
1701 S. Racing Avenue
Chicago, IL 60608-4058

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

RE: ***Deferring Show Cause Order & Closure of Cases***
Case No. 09-1903GC, *et al.* (*see* attached list of 80 group cases[1])

Dear Mr. Berends and Ravindran:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS"), the Providers' designated representative, filed a consolidated request for expedited judicial review ("EJR") on January 12, 2022 for the above-referenced 80 group cases involving, in the aggregate, over 950 participants.[2] On January 20, 2022, the Medicare Contractors' representative, Federal Specialized Services ("FSS"), requested an extension of time to review these 80 cases for jurisdictional issues due to the sheer size of these groups, the number of Medicare contractors involved and pending unresolved jurisdictional challenges filed in at least 8 of the group cases.[3] Shortly thereafter, on January 24, 2022, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") to manage the jurisdictional review process for these 80 group cases and 950+ participants, assigning ongoing tasks to both parties and making known the Board's position that the 30-day period for responding to an EJR request does not begin until the Board finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2). *Following the Board's Scheduling Order, the Providers were* ***silent*** *and* filed ***no objections*** *or requests for clarification with regard to the Scheduling Order*. On February 14, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a lawsuit in the U.S.

[1] The Board has excluded Case No. 20-0162GC entitled "Hartford Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group" from the instant Scheduling Order because it was adjudicated by the Board and closed on March 17, 2022, several weeks prior to QRS' April 8, 2022 letter. Further, the Board added the optional group under Case No. 19-2515G entitled "QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group" which was included in the EJR Request filed on February 16, 2022 that is identical to the one filed on January 20, 2022. *See* Board letter (Jan. 24, 2022) at n.26, n.27 for a more detailed explanation.

[2] *See supra* note 1.

[3] FSS' Response to Providers' Request for EJR (Jan. 20, 2022) identified the jurisdictional challenges as being pending and unresolved in the following 8 group cases:

- Case No. 18-1738GC (JC filed 10/14/21) because the providers improperly expanded the appeal request;
- Case No. 19-0014GC (JC filed 3/8/21) because several providers failed to include the group issue in their hearing request, failed to timely add the issue to their individual appeals and failed to properly transfer into the group and because the group providers improperly expanded their appeal request.
- Case No. 19-0164GC (filed 11/10/21) because: (1) the providers transferred the same issue to another group (Case No. 18-0037GC); and (2) the DSH – Medicaid Fraction/Dual Eligible Days issue was improperly/untimely added.
- Additional jurisdictional challenges have been filed in Case Nos. 14-1171G (filed 8/6/15), 14-1818G (filed 9/14/15), 14-3306G (filed 12/28/15), 14-3308G (filed 12/28/15) and 20-0244G (filed 6/24/21).

District Court for the Central District of California ("California Central District Court") seeking judicial review on the merits of its consolidated EJR request in these 80 cases. On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed the requisite responses. On April 8, 2022, ***roughly 2½ months after the Board's January 24, 2022 Scheduling Order***, QRS broke its silence and informed the Board and the Medicare Contractors of this lawsuit by filing the "Providers *Response* to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903, et at [*sic*]"[4] ("Providers' Response"). In its entirety, Providers' Response stated:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

On April 18, 2022, FSS filed a request for dismissal of the Providers' cases for failure to comply with the Board's Scheduling Orders ("Request for Dismissal"). On April 24, 2022, the Board issued to the Providers an Order to Show Cause Why Dismissal Is Not Warranted ("Order to Show Cause") and the parties filed responses thereto.

As set forth in more detail below, the Board hereby takes the following actions:

1. Closes these 80 cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Defers action on its Order to Show Cause, based on QRS' numerous, egregious, regulatory violations, until such time as there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[5]

Procedural Background

On January 12, 2022, QRS filed an EJR for the above 80 group cases.[6] *In the majority of these group cases*, QRS filed an electronic copy of the Schedule of Providers ("SoP"), with supporting

[4] (Emphasis added.)
[5] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,
[6] *See supra* note 1.

documentation, one or two days prior to the EJR request.[7] Per Board Rule 20.1.1 (Nov. 1, 2021), the SoP must "demonstrate[] that the Board has jurisdiction over ***each*** participant named in the group appeal."[8] Significantly, the overwhelming majority of these cases are *optional* groups and roughly 90 percent of the over 950 participants are in those *optional* groups. As explained at Board Rule 12.3.2 (Nov. 1, 2021), "[p]roviders not under common ownership or control may choose to join together to file an ***optional*** group appeal for a specific matter that is common to the providers for any fiscal year that ends in the same calendar year, but they are not required to do so."[9] In contrast, Board Rule 12.3.1 explains when a mandatory common issue related party ("CIRP") group appeal is required, "[p]roviders under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. See 42 C.F.R. § 405.1837(b)."[10]

On January 20, 2022, FSS requested a 60-day extension of time to review these 80 cases for jurisdictional issues "due to the sheer size of the groups, the recent closure of several of the groups and the number of [Medicare Contractors] involved."[11] FSS also noted that there were pending jurisdictional challenges in 8 of the 80 cases.[12] Finally, FSS noted that jurisdiction is paramount and maintained that its request was consistent with the intent of Board Rules 44.6 and 22 which give Medicare Contractors 60 days to review the final SoP (including the underlying jurisdictional documentation for each participant) and file jurisdictional challenges, as relevant, following receipt of the final SoP.

The January 24, 2022, Scheduling Order explained that, on March 25, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[13] The Scheduling Order further explained that, as the result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis, had resumed telework status.[14] While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decisions. Accordingly, the Scheduling Order notified the parties in this case that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals as follows:

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[7] It appears that, in these situations, QRS was refiling an SoP previously filed.
[8] (Emphasis added.)
[9] (Emphasis added.)
[10] (Emphasis added.) Board Rule 12.3.2 is based on directive in 42 U.S.C. 1395oo(f)(1) and 42 C.F.R. 405.1837(b)(1)(i). In particular, this regulations states: "Two or more providers that are under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal."
[11] FSS' Response to Providers' Request for EJR (Jan. 20, 2022).
[12] *See supra* note 3.
[13] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[14] *See also infra* note 62.

> As you are aware, Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**. Accordingly, the Board: (1) will follow the standards set forth in the CMS regulations at 42 C.F.R. § 405.1801(d)(2) when calculating the Board's 30-day time period by excluding all days where the Board is not able to conduct its business in the usual manner; and (2) has stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.[15]

In addition, the Scheduling Order set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant, documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Further, the Board requested that the record in these cases be supplemented with certain germane information from the individual appeals, from which participants had been transferred, to ensure the record before the Board was complete for purposes of the Board's jurisdictional review.[16] Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that "A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]" [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request)."[17]

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[15] (Footnote omitted and bold and underline emphasis added.)

[16] Specifically, the Board stated: "The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case* ***so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases***." Board letter (Jan. 24, 2022) (emphasis added).

[17] (Emphasis in original.)

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' request for an extension prior to the Rule 44.3 30-day time deadline. Nor did QRS file any objection to the Scheduling Order. QRS was simply silent.

On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed jurisdictional challenges in 15 distinct group cases. These challenges were different from, and in addition to, the 8 pending, unresolved, jurisdictional challenges that FSS noted in its initial January 20, 2022 response.[18]

On April 8, 2022, roughly 2½ months after the Board issued its Scheduling Order, QRS broke its silence to file the 4-sentence Providers Response[19] which, in whole, reads:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

Providers' Response makes clear that the Providers are abandoning the Board's jurisdictional review process and are not complying with the Board's January 24, 2022 Scheduling Order by stating: "*the Providers consider that proceedings before the PRRB have been* ***exhausted*** [and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[20]

On April 18, 2022, FSS filed its Request for Dismissal wherein it requested the Board either: (1) dismiss these 80 cases for "failure to comply with Board rules and deadlines [in the January 24, 2022 Scheduling Order] and for, in essence, abandoning the issues before the Board" by filing a complaint in federal district court; or (2) "[i]n the alternative, . . . dismiss each of the cases for which the MACs have filed jurisdictional or substantive claim challenges."

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[18] *See supra* note 3.

[19] Again, the Board notes that the caption for April 8, 2022 filing clearly notes it was intended as a response to the Board's Notice of Stay and Scheduling Order: "Providers Response to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903GC, et at (See Attached list)"

[20] Board Scheduling Order n.23 (Apr 21, 2022) (emphasis added).

In response to these filings, the Board issued an Order to Show Cause, on April 21, 2022, directing QRS to respond, no later than May 5, 2022, to FSS' Request for Dismissal and to Show Cause why the Board should not dismiss these 80 cases in their entirety based on:

- The Providers' failure to timely respond to the Medicare Contractor's Extension Request or the ensuing January 24, 2022 Board Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- The Providers' abandonment of the Board's ongoing jurisdictional review process and refusal to comply with the Board's Scheduling Order for the management of that review process.

On May 5, 2022, QRS filed a response on behalf of the Providers urging the Board to not dismiss the cases because, "although it is the desire of the Providers to cooperate with the Board and the MAC, the Providers explain the basis for their commencement of an action in federal court, which the Providers continue to believe is legally appropriate, and why the Board should not dismiss these cases." QRS explains that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that they "notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court." QRS contends that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that *the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases*." In taking this position, the Providers readily recognize that they "are aware that there are other extenuating circumstances, such as COVID related staffing issues, which are hampering the Board's ability to process EJR requests."[21] However, "[w]hile sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met." Finally, QRS asserts that "although the Providers have commenced an action in federal court, since the Board appears to believe that it retains authority over these cases, the Providers respond to the jurisdictional issues that Federal Specialized Services ("FSS") has raised."

Given the nature of QRS' response, and the arguments presented therein, the Board issued a Scheduling Order on May 6, 2022, directing that any response by FSS to QRS's filing must be filed no later than May 12, 2022. Accordingly, FSS responded on May 9, 2022 contending that:

1. The Providers' contention in its May 5, 2022 filing that the Board lacked the authority to allow the Medicare Contractors additional time to review and raise jurisdictional challenges was not timely and properly raised.

2. The Providers improperly waited nearly 2 months to advise the Board that such a complaint had been filed. The Providers' contention that CMS was responsible for advising the Board of a complaint's filing is countered by the fact that "there is no record that the summons was

[21] QRS letter dated May 5, 2022 filed in Case No. 09-1903GC, *et al*.

served" and that service did not occur until two months later on April 12, 2022 when an alias summons was issued in the case. Further, "when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed.

3. The Providers failed to timely respond to any of the jurisdictional challenges raised by the Medicare Contractors.

4. After a lawsuit is filed, 42 C.F.R. § 405.1842(h)(3)(iii) does not prohibit further Board action to determine jurisdiction.[22]

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced 80 cases.

A. The 30-day Period For Responding to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[23]

[22] 42 C.F.R. § 405.1842(h)(3)(iii) states, "If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved."
[23] (Emphasis added).

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
>
> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.
>
> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.

> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[24]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[25] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[26]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Note that the Board's use of the term "stay" (as used in this

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[24] (Emphasis added).
[25] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).
[26] (Emphasis added.)

and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[27] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[28] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[29]

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[27] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[28] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[29] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, would still able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[30] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 80 group cases, with over 950 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[31] process is important to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Indeed, these concerns are very real and evident in these 80 group cases.

In compliance with the Board's January 24, 2022 Scheduling Order, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. On March 14, 2022, FSS timely filed a comprehensive response noting that Jurisdictional Challenges and/or Substantive Claim Challenges had been filed in 15 of the 80 group cases encompassed in the instant EJR request. These challenges as well as separate challenges or jurisdictional issued raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenges claiming that, pursuant to 42 C.F.R. § 405.1889(b), certain providers had no right to appeal a revised NPR for the group issue. Cases affected include Case Nos. 13-3191GC, 13-1440G, 13-2678G, 13-2693G; 14-1174G; 15-1067G; 15-2385G, 20-0250G, 20-0244G.

- Jurisdictional challenges identifying certain participants may not have been validly transferred from an individual appeal into the relevant group because the issue that the participant sought to transfer was not properly part of the individual appeal (*i.e.*, was

[30] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.
[31] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

neither properly part of the appeal request nor properly added pursuant to 42 C.F.R. §§ 405.1835(a)-(b), (e)). In some situations, the Medicare Contractor has suggested that the transferred issue is narrower than the group issue and, as such, that there has been an improper attempt to expand the issue from the individual appeal. Cases affected include Case No. 13-3191GC, 13-2678G, 15-2385G, 18-1738G, 19-0014GC, 19-0164GC.

- Jurisdictional challenges arguing that certain providers should be dismissed because they were already a participant for the same issue and year in another appeal. Cases affected include Case Nos. 15-0018G, 15-3031G, 15-3039G and 19-0164GC.

- Jurisdictional challenge claiming that certain providers should be dismissed because they appealed prematurely under 42 C.F.R. § 405.1835(c) for failure to timely issue a determination. Cases affected include 15-0018G and 15-1419G.

- A jurisdictional challenge that Case No. 15-1067G is not valid because the group failed to meet the minimum $50,000 amount in controversy as documented in the SoP and supporting documents filed for this group.

- A jurisdictional challenge in Case No. 15-2385G alleging that there is no documentation establishing that a provider was properly transferred into the group.

- Jurisdictional challenges identifying multiple providers that were ***improperly*** listed in the SoP after they were ***previously*** withdrawn by QRS, dismissed by the Board or its transfer to the group was denied. Cases affected include Case Nos. 13-2678G, 13-2693G, 13-1440G, 14-1174G, 15-1419G, 15-3031GC, and 15-3039G.[32]

- Jurisdictional challenges claiming that, because certain providers are commonly owned or controlled, they could be required to be part of a mandatory CIRP group. Accordingly, they may not be a participant in the relevant optional group and could be subject to dismissal. Cases affected include Case Nos. 15-1419G, 15-3031G, 18-1259G, 18-1260G.[33]

- Jurisdictional challenges raising questions whether QRS was an authorized representative of certain participants. Cases affected include Case Nos. 13-2678G, 13-2693G, 15-2385G.

- Jurisdictional challenges in Case No. 16-1142G, 18-1259G, and 18-1260G averring that the determination at issue for a participant was not included as required by 42 C.F.R. § 405.1835(b) and should be reviewed for dismissal.

[32] Most of the challenges for the withdrawn/dismissed participants are raised through exhibits attached to the jurisdictional challenges showing correspondence either from QRS withdrawing the participant or from the Board dismissing the participant and/or denying transfer to the relevant group.

[33] In one situation, the Medicare Contractor has identified a CIRP group for the same issue and year in which it believes the provider is a participant and, if so, that duplication would be a clear violation of the mandatory CIRP regulation and Board Rule 4.6 prohibiting duplicate appeals. In another, the Medicare Contractor identified 2 CIRP providers participating in the same *optional* group with an aggregate amount in controversy in excess of $50,000, which if true would violate the mandatory CIRP regulation.

- Jurisdictional issues noted in Cases No. 20-0248, 20-0250G, and 20-0411GC regarding certain providers that failed to properly establish an individual appeal prior to transferring to the group because they failed to *timely* file their individual appeal within the period allowed by 42 C.F.R. § 405.1835(a)(3).

- Jurisdictional challenges filed in Case Nos. 14-1818G, 14-3306G, 14-3308G allege that certain providers did not include a claim for the item on their cost report and did not identify the item as a self-disallowed cost by identifying the issue as a protested amount on their cost report.

- A substantive claim challenge[34] was filed for Case No. 19-2513 claiming that none of the providers included an appropriate claim for the appealed item in dispute as required under 42 C.F.R. § 413.24(j).

In addition, the Board through its ongoing review of jurisdiction, and other procedural issues, in these 80 group cases, has identified ***numerous, material,*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The issues and concerns identified by the Board include, but are not limited to, the following.

1. *Prohibited Duplicate Appeals*

   There are violations of Board Rule 4.6 prohibiting duplicate appeals. For example, the participants in Case No. 09-1903GC (BHCS 07 DSH Dual Eligible Days) are duplicative of the participants, and the cost reporting periods, at issue in Case Nos. 13-3896GC and 13-3938GC.

2. *Providers With No Appeal Rights*

   There are additional providers that, pursuant to 42 C.F.R. §405.1889(b), had no right to appeal a revised NPR for the group issue. Other examples outside of those identified by the Medicare Contractors include Case Nos. 20-0248G and 20-0250G.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants in Excess of $1 million*

   There are a significant number of participants in these 80 groups for whom QRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though they were either ***previously withdrawn by QRS*** from the relevant group case, the Board denied the transfer to the group appeal ***or*** the Board dismissed them. Although the Board has not completed its review, the following examples from only 8 of the 80 cases alone demonstrate that QRS is ***improperly*** pursuing reimbursement ***in excess of $1 million.***

[34] *See supra* note 31 (discussing what the Board's use of the term "substantive claim challenge" means).

Such action on the part of QRS raises significant fraud and abuse concerns,[35] and the Board takes administrative notice that this is not an isolated concern. Fraud and abuse concerns naturally arise in instances where a provider (or a provider representative) fails to follow Board Rules and the Board's governing regulations[36] by: (a) pursuing prohibited duplicate reimbursement claims for the same issue and year in multiple cases; or (b) pursuing reimbursement for issues that were previously formally withdrawn, or dismissed, and have not been reinstated by the Board. *To this end, a group representative has a responsibility to track and manage its cases and ensure due diligence is exercised* ***prior to*** *making filings.* Recent examples of group cases in which the Board has identified that QRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals; ***or*** prior group cases in which withdrawals were ***required*** under settlement with the government but were not withdrawn, even after notification was sent to QRS separately by the relevant Medicare contractor or FSS

[35] Based on its preliminary review of just some of these cases, the Board fully expects to identify a significant number of other situations where QRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of the SoPs that QRS refiled and is relying on for its consolidated EJR request (*e.g.*, relying on 9+ year old SoPs in Case Nos. 13-3942G and 13-3944G where there are 106 participants in the aggregate). Indeed, the Medicare Contractors have already identified some of these other situations. *See supra* note 32 and accompanying text. Further, in its May 5, 2022 response to the Board's Show Cause Order, QRS sets forth in Exhibit 4 a listing of the 14 previously withdrawn/dismissed providers that the Medicare Contractors had identified *with an AIC in the aggregate of $1,054,115.* Seven of these 14 (with an aggregate AiC of $476,115) overlap with the Board's preliminary listing, *infra*, of previously withdrawn/dismissed providers:

- Case No. 13-2678G – #22 Leesburg RMC and #27 Union General Hospital; and
- Case No. 13-2693G – #26 Wuesthoff MC;
- Case No. 14-1174GC – #19 Shands Jacksonville Medical Center, #23 Leesburg Regional Medical Center, #28 Union General Hospital, and #39 MedCenter One Inc.

The ones not on the Board's list have an aggregate AiC of $578,000 and include:

- Case No. 13-2678G – #38 St. Alexius MC and #39 Bismarck MedCenter One;
- Case No. 15-0018GC – #4 Cox Medical Center;
- Case No. 15-1419G – #1 Lawrence & Memorial Hospital on SoP-A and #21 FF Thompson Hospital on SoP-B;
- Case No. 15-3031G – #26 Wilkes Regional MC; and
- Case No. 15-3039G – #25 Wilkes Regional MC.

Accordingly, the AiC of Board's preliminary listing of previously withdrawn/dismissed participants would increase from $1,038,115 to ***$1,616,115*** if these additional 7 are included. The Board is confident that it would identify additional instances if it were to complete its jurisdictional review process (*e.g.*, the Medicare Contractors identified Case Nos 13-1440G (C-4) and 14-1171G as having previously withdrawn/dismissed providers but those cases are ***not*** on QRS' list of 14). The Board listing, plus the Medicare Contractors listing, demonstrates the hollowness of QRS' offer to simply withdraw the 14 Providers the Medicare Contractors identified (roughly 30% of what has thus far been identified this issue). This is more than a mere oversight, as QRS clearly failed to exercise any, much less due, diligence, when it resubmitted stale SoPs concurrent with the consolidated EJR request.

[36] *See, e.g.*, 42 U.S.C. § 3729 (False Claims Act).

include: Case Nos. 10-0924GC,[37] 12-0281G,[38] 13-3075,[39] 13-3928G, 13-3941G,[40] 14-4385GC, 14-4386GC,[41] 14-4171GC, 14-4172GC,[42] 15-0020G, 15-1423G,[43] 15-0585GC, 15-0587GC,[44] 15-3484GC,[45] 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, 16-1349GC,[46] 17-0568GC, and 19-2376GC. [47] These examples highlight, *at a minimum*, QRS' reckless disregard for its

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[37] As part of an EJR determination dated August 2, 2019, the Board notified QRS that it had *improperly* included Participant #1 on the SoP because it had filed a void transfer request to transfer from a case which the Board had closed more than 3 years earlier -- Case No. 08-1716.

[38] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly"* included Participant #9 on the SoP because the Board previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeal.

[39] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly"* included a Provider on the SoP for Case No. 13-3075GC because, on October 24, 201**3**, the Board had previously denied the request to transfer because the Provider did not timely appeal the issue for which transfer was requested.

[40] As part of an EJR determination dated April 8, 2019, the Board notified QRS that it had "*improperly"* included Rapid City Regional Hospital as a participant in the SoPs for Case Nos 13-3928G and 13-3941G because the Board previously had issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[41] As part of an EJR determination dated June 24, 2019, the Board notified QRS that the SoP for Case Nos. 14-4385GC and 14-4386GC had failed to comply with Board rule by "*improperly*" including Scottsdale Osborn Medical Center because the Board had previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[42] As part of an EJR determination dated September 30, 2021, the Board admonished QRS for "*improperly*" including Mercy Hospital Springfield on the SoP for Case No. 14-4171GC and 14-4172GC because the Board had issued a jurisdiction determination on March 25, 201**5** dismissing the dual eligible days issue as untimely added to Case No. 14-0460 and denying transfer from Case No. 14-0460 to the respective group appeals. The Board reminded QRS that it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings.

[43] As part of an EJR determination dated April 11, 2019, the Board notified QRS that it had "*improperly*" included Lawrence & Memorial Hospital on the SoP for Case No. 15-0020G and 15-1423G because the Board previously issued a determination dated November 7, 2016 (as modified by letter dated December 12, 201**6**) denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[44] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly*" included 3 different providers on both the SoP Case Nos. 14-0585GC and 15-0587GC because, by letters dated May 14, 2015, July 9, 2015, November 17, 2015, the Board had denied transfers of those 3 providers to both Case Nos. 14-0585GC and 15-0587GC.

[45] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly*" included a provider on the SoP even though the Board had denied jurisdiction in the individual appeal and denied transfer therefrom on February 23, 201**6** and, *following a request for reconsideration*, ***upheld*** that denial by letter dated June 17, 201**6**.

[46] QRS failed to withdraw a provider from Case Nos. 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, and 16-1349GC even though: (1) the Bankruptcy Settlement Agreement entered into between the Provider and the CMS in June 2021 required within 30 days of the Bankruptcy Settlement Agreement's effectuation to "withdraw their participation in PRRB Appeals . . . or appeals pending in any venue or jurisdiction"; (2) On September 1, 2021 ,the Medicare Contractor notified QRS by email of its obligation to withdraw per the agreement; and (3) on September 17, 2021, the Medicare Contractor filed a Request for Dismissal of that provider from these cases based on QRS' in action. Notwithstanding, QRS took no action and, in particular, did not respond within the 30 days allotted under Board Rule 44.3 and, accordingly, the Board dismissed the provider and reprimanded QRS for its failure to comply with the Bankruptcy Settlement Agreement.

[47] In a Board determination dated August 12, 2020 on a Medicare Contractor challenge to certain issue transfers, the Board reopened Case No. 17-0568 to dismiss 2 providers that had *improperly* transferred from 10+ month ***closed*** cases, and reopened and rescinded the EJR determination for Case No. 17-0568GC in order to effectuate the void/invalid

basic responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 1,500 open cases (of which there are more than 1,000 CIRP groups and 130 optional groups), QRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board[48] as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[49]

Especially egregious examples of QRS's failure to competently fulfil its responsibilities as a Provider Representative *in 8 of the instant 80 group cases* include:

a. Case No. 13-1419G – On January10, 2022, 2 days prior to filing its EJR request, QRS refiled what it identified as its original SoP dated June 4, 2014.[50] However, nearly 6 years after filing the original SoP, and nearly 2 years before refiling it as part of its EJR request, QRS *filed* ***in OH CDMS***[51] its withdrawal of Participant #11, St. Francis North Hospital (Prov. No. 19-0197, FYE 6/30/2006, amount in controversy ("AiC") $330,000) on February 25, 2020. Under Board Rules, withdrawals are self-effectuating.[52] Despite its withdrawal, QRS has continued to improperly include St. Francis North Hospital on the Final Schedule of Providers and pursue reimbursement.

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transfers and dismissals. Further, the Board dismissed those same two providers from Case No. 19-2376GC as it had bifurcated from 17-0568GC and their participation in Case No. 19-2376GC depended on the validity of was dependent on that bifurcation. Finally, the Board admonished QRS, as the Group Representative (as well as the Representative in the individual cases) for submitting transfer requests from these individual appeals to Case No. 17-0568GC that they should have known were both invalid and void since the individual cases had been closed for over ten months when the transfer requests were made. The Board reminded them that as representatives they have the responsibility to track and manage their cases and ensure they exercise due diligence prior to making filings.

[48] The Board has identified one SoP where QRS noted withdrawals. The SoP for Case No. 15-0018G that is attached to the January 12, 2022 consolidated EJR request shows an example of an SoP where QRS *correctly* noted 2 separate providers that were previously withdrawn – Participant #3, Prov. No. 19-0125, on SoP-A and Participant #20, Prov. No. 33-0074, on SoP-B. Similarly, the cover letter to the SoP filed in Case No. 14-2217GC includes the withdrawal of 2 participants, Prov. Nos. 340158 and 34-0183, and neither of these withdrawn participants were included on the attached SoP.

[49] For example, QRS filed an *amicus curiae* brief in support of the hospitals position in the case, *Baptist Memorial Hospital-Golden Triangle v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009) ("*Baptist*"). In *Baptist*, the D.C. Circuit found the following: "Notwithstanding the clear directions in the [PRRB] Instructions, the hospitals *gamely* argue that they did not need to follow the Instructions to reinstate a previously **dismissed** appeal. . . . The hospitals cannot so easily evade the plain meaning of the Instructions. The relevant reinstatement provision quite clearly explains how to reinstate appeals for failure to file a timely position paper and lists certain requirements for doing so—including that the party "explain in detail" its reason for non-compliance." (Emphasis added.)

[50] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[51] The Board's electronic filing system is known as the Office of Hearings Case and Document Management System ("OH CDMS") and was launched on a voluntary basis in August 2018. The Board implemented mandatory electronic filing on November 1, 2021. The OH CDMS records readily available to the parties for Case No. 13-1419G show that Philip Payne of QRS filed the request for withdrawal on February 25, 2020 at 3:04 pm.

[52] *See* Board Rule 46 (stating "NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice

b. Case No. 13-1440G – On January 10, 2022, 2 days prior to filing its EJR request, QRS refiled what is identified as its original SoP dated June 4, 2014.[53] However, by letter dated October 16, 2017, the Board issued its decision to QRS denying the transfer of Participant #14, Cape Fear Valley Medical Center (Prov. No. 34-0028, FYE 9/30/2006, AiC $38,000) from Case No. 13-3632 to Case No. 13-1440G. Notwithstanding the denial, QRS has continued to improperly pursue reimbursement for that provider on the Final SoP submitted with the instant EJR Request and failed to include the Board's dismissal in the documentation attached to that Schedule of Providers.

c. Case No. 13-2678G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoP dated October 27, 2014.[54] However, QRS failed to update the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2014 filing. Furthermore, QRS continues to pursue reimbursement on behalf of these Providers *after* they had been removed from Case No. 13-2678G.

   i. On April 29, 2015, QRS withdrew Participant #22, Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007, AiC $55,115).

   ii. On May 17, 2016, QRS withdrew Participant #18 Shands Jacksonville Medical Center (Prov. No. 10-0001, FYE 6/30/2007, AiC $24,000) following a Board request dated May 7, 2016 for QRS to provide a copy of the missing letter of authorization from the Provider.

   iii. On April 15, 2015, the Board notified QRS that, in connection with Participant #27 Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007, AiC $22,000) the Board was dismissing the DSH Dual Eligible Days (Medicaid and SSI Fraction), and other issues in Case No 13-1904 and denying transfer of that issue to 13-2678G.

d. Case No. 13-2693G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled roughly 4/5 of its original SoP, dated October 27, 2014,[55] and the

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acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").

[53] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached the SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[54] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the roughly 1950 pages of attachments.

[55] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2130+ pages of attachments.

remaining 1/5 of that document on January 19, 2022, one week after filing its EJR request.[56] However, in December 2017, the Board notified QRS of its decision to deny transfer of Wuesthoff Memorial Hospital (Prov. No. 10-0092, FYE 9/30/2008) from Case No. 13-2106 to Case No. 13-2693G because the revised NPR at issue did not adjust the issue for which transfer was requested. Notwithstanding, QRS has continued to improperly pursue reimbursement for the Provider as Participant #26 on the SoP with an AiC of $115,000.

e. Case Nos. 13-3942G and 13-3944G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case Nos. 13-3942G and 13-3944G which are each ***dated December 2, 2012***.[57] However, on May 24, 2017, the Board notified QRS of its decision to deny the transfer of Rapid City Regional Hospital (Prov. No. 43-0077, FYE 6/30/2009) from Case No. 14-1297 to Case Nos. 13-3942G and 13-3944G because the Provider did not timely file its individual appeal request. Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #47 on the SoP for Case No. 13-3942G with an AiC of $21,000 and as Participant #44 on the SoP for Case No. 13-3944G with an AiC of $105,000.

f. Case No. 14-1816G—On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case No. 14-1816G which is dated April 7, 2015.[58] However, on November 18, 2015, the Board notified QRS of its decision to deny the transfer of Larkin Community Hospital from Case No. 14-3904 because the Provider's original individual appeal request did not include the SSI fraction dual eligible days issue (nor was it timely added to the case). Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #8 on the SoP with an AiC of $44,000.

g. Case No. 14-1174G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled its original SoP, dated March 20, 2015.[59] However, QRS failed to update

[56] As the SoP with supporting documentation and cover letter consists of 2137 pages, QRS divided the filing into 5 parts and uploaded parts 1, 2, 4 and 5 on January 11, 2022 and the missing part 3 on January 19, 2022, a week after it had filed the consolidated EJR request on January 12, 2022.

[57] While the cover letters transmitting the SoPs with supporting jurisdictional documentation for Case Nos. 13-3942G and 13-3944G are dated December 30, 2014 and December 26, 2014 respectively, each of the attached SoPs list the "date prepared" as December 2, 2012. Further, the caption for the filing in OH CDMS identifies these filings as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the aggregate roughly 3900 pages of attachments to these SoPs (1980+ pages for Case No. 13-3942G and 1900+ pages for Case No. 13-3944G).

[58] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated April 28, 2015 and the attached SoP lists the "date prepared" as April 7, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 863 pages of attachments.

[59] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated March 31, 2015 and the attached SoP lists the "date prepared" as March 20, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2250 pages of attachments.

the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2015 filing and, as such, is improperly pursing reimbursement on behalf of these providers.

i. By letter dated April 7, 2015, the Board notified QRS that the Board was dismissing Case No. 13-2753 for Bismarck MedCenter One (Prov. No. 35-0015, FYE 12/31/2007) in its entirety and denied transfer of the DSH SSI Fraction/Dual Eligible days issue to Case No. 14-1174G. QRS has continued to improperly pursue reimbursement for the Provider as Participant #39 on the SoP with an AiC of $50,000.

ii. By letter dated April 15, 2015, the Board notified QRS that the Board was dismissing all issues except the rural floor budget neutrality adjustment ("RFBNA") issue in Case No. 13-1904 for Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007) because QRS *only* obtained authorization to act on behalf of the Provider for the RFBNA issue. Accordingly, the Board denied the transfer of the Dual Eligible Days (Medicaid & SSI fractions) issue from Case No. 13-1904 to Case No. 14-1174G. However, QRS has continued to improperly pursue reimbursement for the Provider as Participant #28 on the SoP with an AiC of $10,000.

iii. On April 29, 2015, QRS filed its request to withdraw Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite its withdrawal, QRS continues to improperly pursue reimbursement for the Provider as Participant #23 on the SoP with an AiC of $138,000.

iv. On May 17, 2016, QRS filed its request to withdraw Shands Jacksonville (Prov. No. 10-0001, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite this withdrawal, QRS has continued to improperly pursue reimbursement for the Provider as Participant #19 on the SoP with an AiC of $86,000.

4. Prohibited Participation of CIRP Providers in Optional Groups

There are additional violations, or potential violations, of the mandatory CIRP group requirements at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R § 405.1837(b)(1). For example, on March 17, 2022 (several weeks prior to QRS' April 8, 2022 letter), the Board issued a request for additional information in two *optional* group cases (Case Nos. 19-2513G and 19-2515G), identifying potential CIRP compliance issues and QRS submitted a partial response.[60] The Board has a similar open inquiry from January 2021 on the participation of Deaconess Medical Center in Case No. 17-1412G notwithstanding the fact that the provider is part of Empire Health and Empire Health has an open CIRP group for the same issue and year under Case No. 17-0554GC. Upon further review, the Board would issue similar

[60] The mandatory CIRP regulation applies to commonly owned ***or*** *controlled* providers. QRS' response failed to address one provider and, for 2 providers, the response did not adequately address whether there was "control" (*e.g.*, control of the provider through a management agreement).

development letters for CIRP issues identified in other groups, including Case Nos. 13-1419G, 13-3942G, 13-3944G 15-0018G, 15-1419G, 15-3039G, and 16-1750.

5. *Unauthorized Representation of Participants*

   The Board has identified multiple situations where QRS failed to obtain proper authorization from the provider to be a participant in the relevant group. In these situations, the Board has dismissed the provider from the group. For example, in Case No. 13-1419G, QRS failed to provide documentation of proper authorization from Participant #2, Pacifica Hospital of the Valley ($13,000 AiC). Board Rule 5.4 (Mar. 2013) specifies that "[t]he letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider" and "must reflect the Provider's fiscal year under appeal." Contrary to Board Rule 5.4, the authorization letter is not on hospital letterhead and does not identify the organization to which the signatory belongs.

6. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— The majority of the 950+ participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[61] The Medicare Contractors, as discussed *infra*, have already identified issues with some transfers and the Board expects it would identify additional issues if it were to complete its jurisdictional review.

7. *Participants that Fail to Have Both Issues Covered by the EJR Request*.— The EJR request pertains to the DSH adjustment calculation and covers two separate issues where one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation. Thus, for each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that some providers are participants in only one of the fraction groups (*e.g.*, a participant in the SSI fraction group but not the Medicaid fraction group or vice versa). In those instances, the Board must assess whether the provider can remain in the group and, if so, to what extent the EJR applies.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, in its April 8, 2022 filing, that it had abandoned the Board's jurisdictional review process as discussed above. QRS reinforced its intent in the Providers' response to the Board's Order to Show Cause, as shown by the following excerpts:

[61] The Board notes that the window in which issues can be added to an individual appeal is limited by regulation at 42 C.F.R. § 405.1835(e) which states in pertinent part: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. § 405.1835(b) and Board Rule 8 for content and specificity requirements for issues being appealed.

- "The Board, however, failed to render its decision within the thirty-day period. Instead, partly at the request of FSS, the Board informed the Providers that the Board required an additional sixty days to review jurisdictional documents.[1]"

- Footnote 1, appended to the above quote, reads: "*The Providers are aware that there are other* ***extenuating circumstances***, such as COVID related staffing issues which are hampering the Board's ability to process EJR requests. While certainly sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met. The Providers' filing of their EJR complaint, therefore, should not be viewed as casting aspersions on the pace with which the Board is addressing these issues in any way. It simply reflects the objective fact that a decision was not issued within thirty days."[62]

While QRS' April 8, notice did not provide the case number assigned to the Complaint the Providers filed in federal court, PACER (the federal courts' filing system) verifies that the Providers' Complaint, relevant to this decision, was filed in federal district court on February 14, 2022. However, QRS waited nearly two months (54 days) to notify the Board, FSS and the Medicare contractors of the Complaint and its position that the Board proceedings were otherwise

[62] Provider's Response to FSS' Request for Dismissal at n.1 (May 5, 2022). In this situation, it is unrealistic and naive for QRS to expect the Board to complete the prerequisite jurisdictional review process, as well as a review of the EJR request, itself within 30 days. The unreasonableness of QRS' position is highlighted by the following facts:

- The consolidated request consists of 80 cases involving over 950 participants;
- The SoPs with supporting documentation involve tens of thousands of documents. For example, the 8 cases identified as improperly listing previously dismissed/withdrawn participants (Case Nos. 13-1419G, 13-1440G, 13-2678G, 13-2693G, 13-3942G, 13-3944G, 14-1174G, and 14-1816G) involve, in the aggregate, nearly 12,500 pages of attachments which averages to roughly 40 pages per participant (12,473 pages/315 participants). Projecting that to the 950+, the Board estimates that the SoPs for these 80 cases involve over 37,000 pages of documentation related to jurisdiction.
- The majority of the cases at issue are legacy cases and were not filed initially in OH CDMS. As a result, the jurisdictional documentation was filed in hard copy.
- The Agency, including the Board has been in maximum telework status since March 2020 with limited and, at times, no access to hard copy files and filings. Indeed, during the 30 days immediately following the filing of the January 12, 2022 consolidated EJR request, the Baltimore/DC metro area was experiencing the effects of the surge in COVID-19 cases due to the Omicron variant and the Agency remained in maximum telework status and no staff members were in the Board's offices until mid-February 2022 when certain skeletal staff members began coming into the Board's offices. The Agency only lifted that status on May 23, 2022.
- Review and navigation of scanned PDF copies of SoPs is exponentially more time consuming that review of a hard copy SoP that is tabbed and documents can be accessed both horizontally and vertically. As set forth in Board Rule 21, the SoP is organized by participant (Tab 1 is participant 1, Tab 2 is participant 2, etc.) and each participant's jurisdictional documents are organized by Tabs A through H. An example of horizontal access is reviewing the jurisdictional documentation provider by provider. An example of horizontal access is solely looking at the representation letter housed behind Tab H of each provider and this type of access is important for purposes of consistency and quality control. As the PDF documents upload here do not have bookmarks, vertical navigation is not an immediate resource. Some of the optional groups are very large making navigation of an SoP, such as flipping between providers, very challenging. For example, Case No. 13-2693G involves 54 participants and the SoP is spread across 5 pdf documents containing 2137 pages, in the aggregate (and, again, contains no bookmarks to facilitate navigation).

"exhausted"/done.[63] This delay caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 950+ participants in the 80 group cases.[64] More concerning is QRS' attempt to undermine, and bypass, the Board's regulatory and statutory duty to conduct a complete and thorough jurisdictional review process for all of the participants in these cases. QRS essentially self-declared that all 950+ participants in these groups have a right to pursue EJR in federal district court (regardless of whether the Board has jurisdiction over such providers, including instances of previously dismissed or withdrawn providers). If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid.[65]

Accordingly, based on QRS' failure to comply with the Board's filing deadline set forth in its Scheduling Order, the Board exercised its authority under 42 C.F.R. § 405.1869(b)(2) and required QRS to show cause why the Board should not dismiss the appeals in the attached listing based on:

- QRS' failure to timely respond to the Medicare Contractor's Extension Request or the Board's ensuing Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- QRS' abandonment of the Board's ongoing jurisdictional review process, and refusal to comply with the Board's Scheduling Order for the management of that review process.

B. Board Deferment of its Order to Show Cause Why Dismissal is Not Appropriate

42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

[63] While the notice identified the jurisdiction in which the lawsuit was filed, it did not include either a copy of the complaint, the date the lawsuit was filed, or the case number established for the lawsuit.
[64] The Board takes administrative notice that it has a very large docket of pending cases (9485 as of April 1, 2022) and is processing many EJR requests involving multiple thousands of participants. As of April 8, 2022, ***in addition to*** *the 80 cases covered in this notice*, the Board had 253 cases with EJR requests pending of which 130 were filed by QRS. On or after April 8, 2022, EJR requests were filed for an additional 207 cases of which 154 were filed by QRS. As these cases were primarily group cases, they involved thousands of participants in the aggregate.
[65] As explained *supra*, a partial review of just 8, of the 80, group cases being pursued as part of the ongoing lawsuit reveals previously withdrawn/dismissed participants accounting for approximately $1 million in controversy on the related SoPs.

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> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[66]

The Board initially suggested, in its letter dated April 21, 2022, that the clause "proceedings on the legal question or matter at issue" in § 405.1842(h)(3)(iii) only addressed proceedings "on the substance of the EJR request and does not address pre-requisite jurisdiction or other procedural issues that may arise in an appeal or proceedings before the Board." However, upon further reflection, the Board agrees that this regulation ***bars any further Board proceedings*** in these 80 group cases, including proceedings on pre-requisite jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring consideration of its Order to Show Cause until, or if, the Administrator remands these cases back to the Board.

In response to the Board's April 21, 2022 Order to Show Cause, QRS asserted that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and *reasonably believed that further proceedings before the Board prohibited by regulation*."[67] QRS then stated that it "notified the Board by letter dated April 8, 2022 that [the Providers] had commenced an action in federal court" and that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." QRS further stated that, based on § 405.1842(h)(3)(i), it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit" and "regret that apparently this did not happen, and we apologize for not doing more to proactively notify the Board regarding the filing of the complaint ourselves."

FSS in its May 5, 2022 response, suggested that QRS' response was disingenuous in presuming that the CMS Office of Attorney Advisor would promptly notify the Board of the Providers' lawsuit, filed by QRS, because QRS had failed to properly serve the Secretary until April 12, 2022 with an alias summons:

> Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a

[66] (Emphasis added.)
[67] (Emphasis added.)

> Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.

The Board subsequently reviewed the preambles to the proposed rule, dated June 5, 2004,[68] and the May 23, 2008 final rule[69] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[70]

The final rule includes additional guidance on § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. We do not agree that it would be appropriate for the Board or the

[68] 69 Fed. Reg. 35716 (June 25, 2004).
[69] 73 Fed. Reg. 30190 (May 23, 2008).
[70] 69 Fed. Reg. at 3572

> intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[71]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' filing of the Complaint in the California Central District Court prohibits the Board from conducting any further proceedings on the EJR request for the cases as filed above, including any proceedings related to the prerequisite jurisdiction.

In so ruling, the Board notes that QRS created the confusion surrounding the status of these cases at the Board. QRS readily admits that, once it filed the Complaint in federal district court on February 14, 2022, they "*reasonably believed that further proceedings before the Board were prohibited by regulation*"[72] and stated that they did not notify the Board of that filing because, based on § 405.1842(h)(3)(i), they "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, the Board finds QRS' reliance on § 405.1842(h)(3)(i) to be misplaced and not made in good faith. Namely, it ignores both the Board's ruling in its January 24, 2022 Scheduling Order and the Providers' obligations under Board Rules. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[73] QRS had a duty to communicate early and in good faith with the Board and the opposing party (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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[71] 73 Fed. Reg at 30214-15.
[72] (Emphasis added.)
[73] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> **1.3 Good Faith Expectations**
>
> 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.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), QRS, as the Providers' representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[74]

[74] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board.

In response to the Board's April 24, 2022 Order to Show Cause, QRS asserted that "any theory of wholesale abandonment of so many appeals because the Providers decided to pursue those appeals in Federal court under a good faith understanding of the statute's requirement that the Board decides EJR requests within thirty days, and our good faith understanding that the filing of such a complaint halts further action before the Board, would be mistaken." Further, in its response, QRS is quick to assert that 42 U.S.C. § 1395oo(f)(1) obligated the Board (and the Medicare Contractors) to process its EJR request, ***and*** complete its jurisdictional review of those 80 group cases and the underlying 950+ participants, within 30 days of its filing the EJR request (*i.e.*, by Friday February 11, 2022). However, QRS' reliance on this position glosses over the record, and ignores how its silence interfered with the speedy, orderly and fair conduct of the Board proceedings (both in these cases and others) and prejudiced the opposing parties. Indeed, the following inaction on QRS' part belies its claim in the April 8, 2022 notice to the Board that "proceedings before the PRRB have been exhausted":

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' January 20, 2022 motion to extend the Medicare Contractor's time to file jurisdictional challenges until May 5, 2022, more than 3 months after that motion was filed.[75] Indeed, the tardiness of QRS' opposition is highlighted by the fact that it did not make its opposition known until after that extended deadline had passed by more than 50 days. QRS' failure to file notice with the Board, and serve FSS and/or the Medicare Contractors (*i.e.*, the opposing parties), of its opposition to FSS' request, violates QRS' obligations under Board Rules 1.3, 5.2, and 44.

2. QRS did not notify the Board of its objection to the Board's January 24, 2022 ruling on the extension, and the associated Scheduling Order, until May 5, 2022, more than 3 months after the fact. QRS' failure to file and preserve its objection to the Board's January 24, 2022 ruling and Scheduling Order violates QRS' obligations under Board Rules 1.3, 5.2, and 44 and deprived the Board of an opportunity to consider its ruling and Scheduling Order and, if necessary, correct or clarify that ruling and/or Scheduling Order.[76] The tardiness of QRS' opposition is again highlighted by the fact that it failed to make its opposition known until well after the extended deadline they complain of had passed.

Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[75] QRS' April 8, 2022 filing was 3 sentences long and did not provide this notice.

[76] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make know to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Crop. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

3. On January 24, 2022, the Board made its position as to how the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[77] and Board Alert 19, known to the parties in these cases. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42 C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. Because the Board was not operating normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Order to memorialize and effectuate the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Board's January 24, 2022 Scheduling Order until May 5, 2022. QRS' failure to timely file, and preserve, that objection violates Board Rules 1.3, 5.2 and 44. QRS' delay also interfered with the speedy, orderly and fair conduct of the Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its ruling and, if necessary, correct or clarify it,[78] or take other actions, ***prior to*** Friday, February 11, 2022 (*i.e.*, prior to the end of the alleged 30-day deadline from January 12, 2022). QRS' delay allowed the 30-day EJR review deadline, as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (that QRS now alleges the Board missed), to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[79]

4. In its January 24, 2022 Scheduling Order, the Board set forth its process for conducting jurisdictional review. In addition to specifying time for the Medicare Contractors to file jurisdictional challenges and the Providers to respond to those challenges, the Board included the following directive to the parties to supplement the record in these group cases "*to ensure the record before it in these group cases is* ***complete***"[80]:

> The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board*

[77] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).
[78] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 5, 2004 proposed rule. *See supra* notes 70 and 71 and accompanying text.
[79] *See supra* note 76 (discussing how the FRCP supports the Board's position).
[80] (Emphasis added.)

> *rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases.*

QRS blatantly disregarded, and failed to address the Board's directive, to supplement the record relative to jurisdiction.[81] *As the overwhelming majority of the 80 group cases* involved participants that transferred from individual cases formed under the legacy docketing system, the Board's directive applied to the great majority of the 80 group cases. The Board agrees with FSS' statement, in its April 18, 2022 Request for Dismissal, that "the Board's Orders are not aspirational and the Providers' basis for disregarding them is unsupported (and unsupportable) by either law or fact."

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). This occurred, despite the fact that, at that point in time, QRS claimed to "reasonably believe[] that further proceedings before the Board were prohibited by [the] regulation" at 42 C.F.R. § 405.1842(h)(3)(iii). QRS points to the statement in 42 C.F.R. § 405.1842(h)(3)(i) that "the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and copy of the compliant." QRS further contends that it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, that does not mean that QRS did not have an affirmative obligation to *promptly* notify the Board of the lawsuit, and a further specific obligation to notify the Board of the lawsuit based on the circumstances of the Board proceedings. The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

    a. The Board, in its Scheduling Order, made clear its position that the 30-day period for responding to the EJR request had not yet commenced. Further, the Scheduling Order directed both parties to submit certain jurisdictional related information, over a 90-day time frame, relevant to these 80 group cases and the underlying 950+ participants.

    b. Both the Board and the Medicare Contractors were acting in reliance on the authority of that Scheduling Order.

[81] The Board notes that the Medicare Contractors *did respond* to this portion of the Scheduling Order and *did file* copies of pending/unresolved jurisdictional challenges in individual appeals that impact participants in these 80 group cases. Indeed, the Board believes that it was as a result of this directive that the Medicare Contractors identified previously withdrawn/dismissed providers where challenges in individual appeals had been resolved through dismissal/withdrawal and denial of transfers. *See supra* note 32 and accompanying text.

c. QRS' position is dependent upon promptly effectuating service on the Secretary, and FSS contends that this service was not actually effectuated until on April 12, 2022, more than two months later, when an alias summons was issued.[82]

These circumstances make clear that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty."[83] Indeed, QRS' failure to comply with Board Rule 1.3, by promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on or about February 14, 2022, prejudiced the Board, FSS and the Medicare Contractors in other matters. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay, or cease, work on the 80 group cases and the underlying 950+ participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS and other representatives. Indeed, QRS' two-month delay in notifying the Board, and the opposing parties, of the lawsuit filed in the California Central District Court raises concerns about potential prejudicial sandbagging by QRS to benefit subsequent EJR requests that QRS filed on behalf of other providers between January 24, 2022 and April 8, 2022 (*i.e.*, the date QRS gave notification).[84] In this regard, the Board notes that QRS filed EJR requests covering 36 cases with more than 640 participants in the aggregate,[85] of which the overwhelming majority (*i.e.*, greater than 80 percent of the 640+ participants) is associated with a consolidated EJR request filed on

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[82] FSS letter dated May 9, 2022 (stating: "Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.").

[83] It is disingenuous for QRS to suggest in hindsight in its May 5, 2022 response to the Board's April 24, 2022 Order to Show Cause that "[t]he Providers did not respond to the Board's deadlines or to the MAC's filings because [on February 14, 2022] the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that "[t]he Providers notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court" but "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." The Board made its position known in its January 24, 2022 Notice of Stay and Scheduling Order and to the extent QRS had any doubts it had an obligation to seek clarification from the Board. Again, the Board's January 24, 2022 Notice of Stay and Scheduling Order was not aspirational and the Providers' basis for disregarding it is unsupported (and unsupportable) by either law or fact.

[84] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

[85] On February 11, 2022, QRS filed a consolidated EJR request covering 10 group cases with 46 participants, in the aggregate. On February 27, 2022, QRS filed a consolidated EJR request covering 12 group cases with roughly 520 participants, in the aggregate. On March 9, 2022, QRS filed a consolidated EJR request covering 14 group cases with 76 participants, in the aggregate.

February 17, 2022[86] just days after the February 14, 2022 lawsuit was filed.[87] To this point, it is the Board's understanding that, ***prior to*** *the April 8, 2022 notice*, QRS filed an Amended Complaint on March 30, 2022 incorporating these other EJR requests into the lawsuit pending in the California Central District Court (or into new sister lawsuits filed therein).[88] Moreover, it is the Board's understanding that another representative, Healthcare Reimbursement Services, Inc. ("HRS") contemporaneously filed consolidated EJR requests covering 120 group cases with 569 participants in the aggregate,[89] and has joined QRS in lawsuits filed in the California Central District Court, including the one involved with the instant 80 group cases.[90]

As part of its April 8, 2022 notice to the Board, QRS clearly stated that it was abandoning the Board's jurisdictional review process and not complying with the Board's January 24, 2022 Scheduling Order when they stated in their April 8, 2022 filing: "*the Providers consider that proceedings before the PRRB have been* ***exhausted***[and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[91] Further, it is clear the Providers are pursuing the merits of their cases as part of the lawsuit. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[92]

However, the Board cannot permit QRS' reckless disregard for its ***basic*** responsibilities and due diligence, as a representative appearing before the Board (including but not limited to failure to track and account for withdrawn/dismissed providers), its abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, if these cases are remanded, the Board will complete its jurisdictional review and weigh the severity of QRS' violations of, and failure to comply with, Board Rules, regulations and Orders, the prejudice to the Board and the opposing parties, and the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others), and the

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[86] The January 17, 2022 consolidated EJR request covers 12 cases: Case Nos. 13-2324GC, 13-2328GC, 14-1072GC, 14-1073GC, 15-0580GC, 15-0586GC, 15-1622GC, 15-1624GC, 16-0678GC, 16-0679GC, 17-0575GC, and 17-0577GC.
[87] QRS waited until May 19, 2022 to file notice to the Board and the opposing parties that it had filed a lawsuit covering the 12 group cases covered by the February 17, 2022 consolidated EJR request.
[88] The Board will be addressing the status of these other cases under separate cover shortly.
[89] On December 29, 2021, HRS filed a consolidated EJR request covering 63 group cases with 255 participants, in the aggregate. On January 17, 2022, HRS filed a consolidated EJR request covering 40 cases with 200 participants, in the aggregate. On February 27, 2022, HRS filed a consolidated EJR request covering 17 group cases with 114 participants, in the aggregate.
[90] The Board will be addressing the status of these other cases under separate cover shortly.
[91] Board Scheduling Order at n.23 (Apr 21, 2022) (emphasis added).
[92] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

effect on the operations of the Board, when determining what, if any, remedial actions will be taken. Examples of available remedial actions that the Board may consider include, but are not limited to:

1. Dismissal of the 80 group cases and all underlying participants.
2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.
3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[93] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the

[93] 42 C.F.R. § 405.1868 states:

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

(Emphasis added.)

> authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[94]

* * * * *

In summary, 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings, because the Providers are pursuing the merits of their appealed issue in the California Central District Court, and there are no remaining issues beyond the EJR request.[95] Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

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:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danielle Decker, NGS
Pamela VanArsdale, NGS
Cecile Huggins, Palmetto GBA
Byron Lamprecht, WPS
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ms. Nan Chi
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: ***Board Decision***
Houston Methodist Hospital (Provider Number 45-0358)
FYE: 12/31/2013
Case Number: 19-1178

Dear Ms. Chi:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-1178 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 19-1178

On August 22, 2018, the Provider, Houston Methodist Hospital, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2013.

On February 14, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Errors)[1]
3. Bad Debts
4. DGME Payment – Weighting of Certain Residents (FTEs)[2]
5. Non-Approved GME Program Costs[3]
6. Standardized Payment Amount[4]

As the Provider is commonly owned by Houston Methodist Hospital System ("HMHS"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 6 to HMHS groups on September 24,

[1] On September 24, 2019, this issue was transferred to PRRB Case No. 17-1810GC.
[2] On February 27, 2020, the Provider withdrew this issue from the appeal.
[3] On February 27, 2020, the Provider withdrew this issue from the appeal.
[4] On September 25, 2019, this issue was transferred to PRRB Case No. 19-2706GC.

2019, and September 25, 2019, respectively. The Provider withdrew Issues 4 and 5 on February 27, 2020.

The only remaining issues in this appeal are Issue 1, DSH – SSI Percentage (Provider Specific) and Issue 3, Bad Debts.

On October 3, 2019, the Provider filed its preliminary position paper.

On January 28, 2020, the Medicare Contractor filed a jurisdictional challenge with the Board over Issues 1, 4 and 5. This decision only addresses the challenge to Issue 1, the SSI Provider Specific issue, as that is the only issue remaining and all other issues have been transferred or withdrawn. The Provider filed a jurisdictional response on February 24, 2020.

On January 16, 2024, the Provider filed its final position paper. On February 7, 2024, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-1810GC

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

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

[5] Provider's Issue Statement at 1 (Feb. 14, 2019).

The Group Issue Statement in Case No. 17-1810GC, to which the Provider transferred issue #2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395 ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi). T he Providers contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Providers also contend that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days yet refuse to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Providers further contend that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Failure to adhere to required notice and comment rulemaking procedures,

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

On January 16, 2024, the Board received the Provider's Final Position Paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395 ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS 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. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $173,535.

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 duplicative:

> In Issue 1, the Provider contends that the MAC used the incorrect SSI percentage in processing its DSH payment. In Issue 2, the

[6] Group Issue Statement, Case No. 17-1810GC at 1.
[7] Provider's Final Position Paper at 2-3 (Jan. 16, 2024).

> Provider contends that the Secretary improperly calculated its SSI percentage. The Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS. Essentially, the Provider contends that the SSI ratio applied to its cost report was incorrect, the SSI ratio is the underlying dispute in Issues 1 and 2.
>
> Issue 2 has been transferred to a group appeal Case No. 17-1810GC, "QRS Houston Methodist 2013 DSH SSI Percentage (Systemic Errors) CIRP Group."
>
> Board Rule 4.6.1 states that, "(a) Provider may not appeal an issue from a final determination in more than one appeal." The Provider is barred from filing duplicate issues in an individual appeal. Therefore, the Board should find that the SSI percentage is one issue for appeal purposes and that Issue 1 should be dismissed consistent with recent jurisdictional decisions.[8]

Secondly, the MAC argues the Board lacks jurisdiction over SSI realignment:

> Issue 1 includes the Provider's subsidiary appeal over SSI realignment. The Provider states:
>
> > The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[9]

[8] Jurisdictional Challenge at 3 (Jan. 28, 2020).
[9] *Id.* at 4.

Provider's Jurisdictional Response

The Provider timely filed a response to the Medicare Contractor's Jurisdictional Challenge on February 24, 2020. In response to the Medicare Contractor's arguments, the Provider asserts the following arguments:

> The MAC argues [I]ssue 1, SSI Provider Specific/Realignment, is a duplicate to [I]ssue 2 – SSI Systemic issue that the Provider transferred to group appeal PRRB Group Case 17-1810GC, "QRS Houston Methodist 2013 DSH SSI Percentage (Systemic Errors) CIRP Group. Provider contends each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over Case No. [19-1178][.] Board Rule 8.1 states[,] "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…" Appeal [I]ssues #1 and #2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, Provider contends that the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.[10]

Analysis and Recommendation

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 Errors) issue that was appealed in Case No. 17-1810GC.

[10] Provider's Response to the Jurisdictional Challenge at 1 (February 24, 2020).

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[11] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues in its originally submitted issue statement that 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."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 17-1810GC 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 DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-1178 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 17-1810GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board 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, the Provider has failed to explain how this argument is ***specific to this provider***, as the Provider's jurisdictional response asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced.

To this end, the Provider's Final Position Paper does not further clarify Issue 1. The Provider's Final Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits. Instead, the Provider simply reiterated the issue statement it filed with the original appeal request.

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:

---

[11] Provider's Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 2.0 (Aug. 2018).
[15] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)

> 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.

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[16]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

[16] Last accessed March 27, 2024.
[17] Emphasis added.

The Board concludes that the SSI Provider Specific issue in Case No. 19-1178 and the group issue from Group Case 17-1810GC 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 Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as 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 case remains open as there is one issue remaining.

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:

4/3/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Russell Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, #570A
Arcadia, CA 91006

RE: ***Board Decision and Scheduling Order***
Alton Memorial Hospital (Provider Number 14-0002)
FYE: 12/31/2018
Case Number: 23-0663

Dear Mr. Kramer,

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

A. Procedural History for Case No. 23-0663

On August 31, 2022, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On January 26, 2023, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
2. DSH – Medicaid Eligible Days[1]

The remaining issue in this appeal is Issue 1.

On September 22, 2023, the Provider submitted its preliminary position paper.

On January 2, 2024, the Medicare Contractor filed a Jurisdictional Challenge.

On January 12, 2024, the Medicare Contractor submitted its preliminary position paper.

[1] The Provider withdrew this issue on September 21, 2023.

B. Description of Issue 1 in the Appeal Request Case No. 21-1724GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[2]

The Board notes that this Provider is commonly owned by BJC Healthcare, and there is a common issue related party ("CIRP") appeal for the BJC Healthcare SSI Percentage issue that the Provider is ***not*** currently a participant in: 21-1724GC, BJC Healthcare CY 2018 DSH SSI Percentage CIRP Group. The issue statement in that group reads in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to

[2] Issue Statement at 1 (Jan. 26, 2023).

include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

On September 22, 2023, the Provider submitted 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the

[3] Group Issue Statement Case. No. 21-1724GC (September 14, 2021).

> SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[4]

MAC's Contentions

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

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue 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.[5]

Furthermore, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH SSI Unduly Narrow Definition of SSI Entitlement are duplicates.[6] The MAC expands upon the similarities between the issues in its preliminary position paper:

> In describing the issues in its individual appeal request, the provider basically disputes whether the MAC used the correct SSI percentage in computing its DSH calculation. The provider referenced the same audit adjustment numbers for both cases. For

[4] Provider's Preliminary Position Paper at 7-8 (Sep. 22, 2023).
[5] Jurisdictional Challenge at 7 (Jan. 2, 2024).
[6] *Id*. at 4-6.

> Issue 1, the "Provider Specific" issue, the provider contends that it is based on CMS not including all patients entitled to SSI benefits, the SSI percentage is flawed, and they are seeking data from CMS. The provider presents a similar statement for the DSH SSI Narrow Definition of Entitlement issue.[7]

The MAC also contends that the Provider has failed to file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. [8]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[9] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (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." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 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 (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 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 SSI Percentage (Systemic Errors) issue filed by commonly owned entities in PRRB Case No. 21-1724GC.

---

[7] Medicare Administrative Contractor's Preliminary Position Paper at 11-12 (January 12, 2024).
[8] Jurisdictional Challenge at 7-9.
[9] Board Rule 44.4.3, v. 3.1 (November, 2021)

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the group issue in Case No. 21-1724GC. The first aspect of Issue 1 in the present appeal concerns "whether the [MAC] 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 SSI Data Match CIRP Group in Case No. 21-1724GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 21-1724GC, for other commonly owned entities and the same fiscal year. Pursuant to 42 C.F.R. § 405.1837(b)(1):

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

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, BJC Healthcare is pursuing that issue as part of the group under Case No. 21-1724GC for other providers which are under the same parent corporation. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] 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 issue appealed in Case No. 21-1724GC, even if the Provider considers that issue to be "systemic" issues rather than "provider specific."

Accordingly, the Board finds that Issue 1 and the group issue in Case No. 21-1724GC are the same issue. Because the issue is duplicative of the specific matter appealed in the group appeal

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[10] Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 1.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co*., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

for which there are other providers under the same common ownership as the Provider in this case, and the group in Case No. 21-1724GC is not yet fully formed,[14] ***the Board is giving the Provider 10 days from the date of this letter to transfer this issue to Case No. 21-1724GC***, in order to become compliant with the CIRP regulation, quoted above. Accordingly, failure of the Provider to respond by the above filing deadline will result in the dismissal of this case. With the transfer of the issue, no issues will remain in the appeal.

Even if the issue were not duplicative, the Board also finds that the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[15]

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:

---

[14] *See* 42 C.F.R. § 405.1837(e), which provides that when the Board has determined that a group appeal brought under paragraph (b)(1) of this section (quoted above) is fully formed, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.

[15] (Emphasis added).

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

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1724GC are the same issue, and requires the transfer of the issue to the CIRP group appeal.

2. *Second Aspect of Issue 1*

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

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate that the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

****

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) is duplicative of the group issue being pursued in Case No. 21-1724GC, and therefore, the Provider has **10 days from the date of this letter** to transfer that aspect of Issue 1 to Case No. 21-1724GC, in order to comply with 42 C.F.R. § 405.1837(b)(1).

Further, there is no final determination from which the Provider can appeal the SSI realignment issue within Issue 1, and therefore that aspect of Issue 1 is dismissed.

[16] Last accessed April 1, 2024.
[17] (Emphasis added).

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:

4/4/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Board Decision***
Lea Regional Medical Center (Provider Number 32-0065)
FYE: 12/31/2015
Case Number: 19-0983

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0983 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 19-0983

On July 17, 2018, the Provider, Lea Regional Medical Center, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On January 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. Disproportionate Share Hospital (DSH) – Supplemental Security Income (SSI) Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Issues)[1]
3. DSH – Medicaid Eligible Days[2]
4. DSH – Uncompensated Care (UCC) Distribution Pool[3]
5. DSH – 2 Midnight Census IPPS Payment Reduction[4]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and, thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4 and 5 to CHS groups on July 19, 2019.

[1] On July 19, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On February 26, 2024, the Provider withdrew Issue 3 from the appeal.
[3] On July 19, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On July 19, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

Issue 3 was later withdrawn on February 26, 2024. After all transfers and the Provider's request to withdraw, the only remaining issue in this appeal is Issue 1, DSH – SSI Percentage (Provider Specific).

On August 20, 2019, the Provider filed its preliminary position paper.

On September 25, 2019, the Medicare Contractor filed a jurisdictional challenge over Issue 1. The Provider filed a jurisdictional response on October 29, 2019.

On February 22, 2024, the Provider filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC, "QRS CHS 2015 DSH SSI Percentage CIRP Group"

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

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

The Group Issue Statement in Case No. 18-0552GC, to which the Provider transferred issue #2 reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations

[5] Provider's Initial Appeal Request at 11 (January 3, 2019).

accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

Statement of the Legal Basis

The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi). T he Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.

. . .

The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

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

On February 22, 2024, the Board received the Provider's final position paper in Case No. 19-0983. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Issue # 1 Provider Specific

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

[6] CIRP Group Appeal, Case No. 18-0552GC at 47 (January 18, 2018).

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[7]

MAC's Contentions

The MAC contends that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) because the appeal is duplicative and premature. First, the MAC argues the Provider's appeal is duplicative. The MAC contends:

> Issue 1 has three sub-issues: SSI data accuracy, realignment and SSI payment. The portions of Issue 1 concerning SSI data accuracy and SSI payment are duplicates of Issue 2 and should be dismissed.
>
> In Issue 1, the Provider asserts that "… it's (sic) 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." In Issue 2 the Provider asserts that "…the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed." In both Issue 1 and Issue 2 the Provider is disputing whether the correct SSI percentage was used in computing its DSH payments. The accuracy of data is the underlying issue in both the DSH – SSI percentage Provider Specific issue and the DSH – SSI percentage issue.
>
> . . .

[7] Provider's Final Position Paper at 8 (February 22, 2024).

> . . . Issue 2 was transferred to Case No. 18-0552GC "QRS CHS 2015 DSH SSI Percentage CIRP Group" on July 18, 2019. Board Rule 4.6.1 states that, "(a) Provider may not appeal an issue from a final determination in more than one appeal." Consistent with the Board's previous jurisdictional decisions, the MAC respectfully requests the Board dismiss the portions of Issue 1 concerning data accuracy and individuals who are eligible for SSI but did not receive SSI payment.[8]

Additionally, the MAC argues the Board lacks jurisdiction over SSI realignment and that the appeal is premature, as the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> Issue 1 also includes the Provider's subsidiary appeal over SSI realignment. In its appeal request, the Provider states:
>
> > The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The issue of SSI realignment is still active. Within its preliminary position paper, the Provider states:
>
> The Provider contends that its' [sic] SSI percentage published by the [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). (Emphasis added)
>
> The decision to realign a hospital's SSI percentage with its fiscal year end is a Provider election. It is not a final MAC determination. A Provider must make a formal request to the MAC and 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 formally requested to have its SSI percentage

[8] Jurisdictional Challenge at 5-6 (September 25, 2019).

> 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[9]

Provider's Jurisdictional Response

The Provider timely filed a response to the Medicare Contractor's Jurisdictional Challenge on October 29, 2019. In response to the Medicare Contractor's arguments, the Provider asserts the following arguments:

> Provider contends each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 19-0983.
>
> Board Rule 8.1 states "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…" Appeal issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific /Realignment issues.[10]

The Provider further outlines its arguments as follows:

> SSI Systemic Issue:
>
> The SSI Systemic issue addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp 2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI, including such errors as: not accounting for retroactive SSI eligibility determinations by the Social Security Administration (SSA); omitting days of individuals who were eligible for SSI at the time of their stay due to their records being considered inactive by SSA due to their death following their stay; omitting SSI eligibility records of individuals who received a forced or manual payment on a temporary basis in lieu of the automated payments that are typically used for SSI payments, and the exclusion of days from the numerator of the Medicare Fraction belonging to patients who are not eligible to

[9] *Id.* at 6-7.
[10] Provider's Jurisdictional Response at 1 (October 29, 2019).

receive SSI payments at the time of their stay, but who have a special status under Section 1619(b) of the Social Security Act, 42 U.S.C. § 1382h(b), which enables them to receive Medicaid assistance based on a past entitlement to SSI payments. These systemic errors are the results of CMS's improper policies and data matching process. The SSI Systemic Issue also covers CMS Ruling 1498-R.

SSI Provider Specific Issue:

FSS, on behalf Novitas Solutions, the Medicare Administrative Contractor ("MAC"), challenges the Board's jurisdiction, stating that the Provider does not have a right to a hearing before the Board on the DSH/SSI realignment issue because it is duplicative of the SSI Systemic issue. However, Provider contends that FSS is incorrect. Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. In *Baystate*, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.

Accordingly, this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2015, resulting from its understated SSI percentage due to errors of omission and commission.[11]

Analysis and Recommendation

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.

[11] *Id.* at 2.

1. *First Aspect of Issue 1*

The first aspect of the DSH – SSI Percentage (Provider Specific) issue (Issue 1) in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[12] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues in its issue statement, which was included in the appeal request, that 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."[14] The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 19-0983 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

The Provider's Final Position Paper does not further clarify Issue 1 and fails to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" and include *all* exhibits.

---

[12] Provider's Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 2.0 (Aug. 2018).
[16] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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 (Nov. 2021)**
>
> 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 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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[17]

[17] Last accessed April 1, 2024.

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."[18]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that the SSI Provider Specific issue in Case No. 19-0983 and the group issue from Group Case 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

****

As no issues remain pending, the Board hereby closes Case No. 19-0983 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: For the Board:

[18] Emphasis added.

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

4/4/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services
Michael Redmond, Novitas Solutions (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Anna Stafford
DFW Tender Touch Hospice
dba Archway Hospice
4645 Avon Lane, Suite 225
Frisco, TX 75033

Cecile Huggins
Palmetto GBA (J-J)
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***
DFW Tender Touch Hospice dba Archway Hospice (Prov. No. 74-1753)
FYE 9/30/2022
PRRB Case No. 24-1398

Dear Ms. Stafford and Ms. Huggins:

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

Pertinent Facts:

On February 21, 2024, DFW Tender Touch Hospice dba Archway Hospice (the "Provider") filed an appeal request with the Board to establish Case No. 24-1398. The appeal was filed from a determination entitled "Notice of Effect of Inpatient Day Limitation and Hospice Cap Amount" ("Hospice Cap Determination") dated November 30, 2023.

However, apart from the final determination, the Provider's appeal request did not include:

- an issue statement (Board Rule 7.2);
- a complete Representative letter (Board Rule 5.4) and
- a calculation of the reimbursement impact on the facility (Board Rule 6.4).[1]

On February 22, 2024, the Board issued an Acknowledgement and Critical Due Dates Notice in which it: (1) set a briefing schedule for the Parties to file preliminary position papers; ***and*** (2) requested a Representation Letter, Calculation Support and an Issue Statement. The deadline for the required support documents was set for March 8, 2024. However, the Provider failed to file a response.

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

Accordingly, on March 11, 2024 the Board issued a final request for the Information and gave the Provider a new deadline of March 25, 2024. To date, the Provider has not complied with either of the Board's Requests for Information.

Rules/Regulations:

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

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

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

request requirements of paragraphs (b)(1) and (b)(2) of this section.[2]

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

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

Board Determination:

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

First, the Provider's appeal request failed to include an issue statement consistent with the appeal request content requirements in 42 C.F.R. § 405.1835(b) and Board Rule 7.2. In lieu of an issue statement, the provider submitted its Hospice Cap Determination. (In fact, the Provider submitted copies of the Hospice Cap Determination in lieu of calculation support and audit adjustment support.) While this document identifies the final determination under appeal per 42 C.F.R. § 405.1835(b)(1), it does not include an explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the determination as required in § 405.1835(b)(1).

Second, although the Provider listed an estimated reimbursement impact of $111,430 for the Hospice Cap issue, it failed to include a calculation to support this estimate as required by 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4.

Additionally, the Provider's initial Representative letter does not comply with Board Rule 5.4. Although it was filed on the Provider's letterhead, it does not include the Provider Name, Provider No. and cost year under appeal. Most notably, however, is the omission of the Provider's phone number and email address. As the Board issues all communication via e-mail, this information is critical.

The Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies. The Provider has failed to respond to the Board's February 22, 2024 and March 11, 2024 Requests. Accordingly, the Board hereby dismisses Case No. 24-1398 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above.

Based on the final determination date, the Provider may still be within its appeal period. Therefore, if the Provider elects, it may request the Board reconsider its determination and reinstate the appeal. A request for reinstatement must be filed by the appeal filing deadline (see Board Rule 4.4.1) and must include the missing documentation as noted herein. Please see Board

[2] (Emphasis added.)

Rule 47 regarding reinstatement requirements, as well as 42 C.F.R. § 405.1835 and Board Rules 6 and 7, which discuss *individual provider appeal rights **and** requirements*.

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

Board Members:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/5/2024

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Glenn Bunting
Moss Adams LLP
2882 Prospect Dr., Ste. 300
Rancho Cordova, CA 95670

RE: ***Denial of Motion for Reinstatement***
Dignity Health CY 2013 Medicare Part C Days in Realigned SSI Ratio CIRP Group
Case No. 20-0770GC

Dear Mr. Bunting,

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to the Providers' request for reinstatement ("Motion for Reinstatement") submitted on October 9, 2023. The decision of the Board is set forth below.

Pertinent Facts

On **January 28, 2020**, Moss Adams LLP ("Moss Adams") filed a group appeal request to establish Case No. 20-0770GC entitled "Dignity Health CY 2013 Medicare Part C Days included in CMS Realigned SSI Ratio CIRP Group." At the time of its dismissal, the Common Issue Related Party ("CIRP") group had not been designated to be fully formed and included seven participants ("Providers"):

- Mercy Medical Center (05-0444) (RNPR)
- Marian Regional Medical Center (05-0107) (RNPR)
- Sierra Nevada Memorial Hospital (05-0150) **(**RNPR**)**
- St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012) (RNPR)
- Mercy Medical Center Redding (05-0280) (RNPR)
- Mercy San Juan Medical Center (05-0516) (RNPR)
- St. Rose Dominican Hospitals - San Martin Campus (29-0053) (RNPR)

The group appeal issue filed from receipt of revised Notices of Program Reimbursement ("RNPR") by the Providers is "Medicare DSH Payments – CMS Inclusion of Medicare Managed Care Part C Days in the Realigned SSI Ratio Determined By CMS."

On **September 6, 2023**, the Board issued a letter closing Case No. 20-0770GC finding that it "lacks jurisdiction over the Providers Mercy Medical Center (05-0444), Marian Regional Medical Center (05-0107), Sierra Nevada Memorial Hospital (05-0150), St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012), Mercy Medical Center Redding (05-0280), Mercy

San Juan Medical Center (05-0516), and St. Rose Dominican Hospitals - San Martin Campus (29-0053) that appealed from RNPRs because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals."[1] Specifically, the Board found the RNPRs were a result of SSI Realignment request and did ***not*** adjust the Part C days issue. Therefore, the Providers did not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

As a separate and independent basis for the dismissal, the Board determined the Providers had already appealed the Part C days issue for this specific fiscal year in CIRP group under Case No. 16-1121GC entitled "Dignity Health 2013 DSH SSI/Medicaid Part C Days CIRP Group." As both group appeals were seeking to pursue the same issue, the Board determined Case No. 20-0770GC is a duplicate of Case No. 16-1121GC in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the Board Rules involving duplicate appeals, 4.6.1.

Providers' Request for Reconsideration

On October 9, 2023, the Providers submitted a Request for Reinstatement disagreeing with the Board's decision that it lacks jurisdiction over the appeals filed from the RNPRs. The Providers maintain that they do have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1) and request the reinstatement of Case No. 20-0770GC. The Providers state they have demonstrated the RNPRs for all Providers were "issued as a result of SSI realignment requests, and the RNPRs did adjust the number of Medicare Part C Days for each Provider participating in the group."[2]

The Providers argue that, because the RNPR looks at the Provider's cost reporting year compared to the original NPR looking at the federal fiscal year, there are Medicare Part C days in the RNPR that do not overlap with the original NPR. They state that the SSI ratio datasets for the NPR and RNPR are therefore not identical, and that the original NPR dataset has been superseded by the RNPR dataset according to 42 C.F.R. § 412.106(b)(3). The Providers maintains that it was jurisdictionally proper to appeal SSI ratio realignment readjustments from the RNPR because the different dataset is not covered by the appeal in Case No. 16-1121GC. Therefore, the Providers contend the appeal is not duplicative because each appeal contains different Medicare Part C days in the SSI ratios applicable to the 2013 year. Two separate Common Issue Related Party (CIRP) appeals were created from the NPRs and RNPRs issued by the MAC which cover different groups of data. As a result, it is not a "single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." The Providers state they have provided evidence that CMS has adjusted the number of Part C days for each Provider in the group according to their SSI ratio realignment request. The Providers argue that as a result they do have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

[1] Board Decision (September 6, 2023) at 6.
[2] Provider Request for Reconsideration at 5.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841, a group of providers have a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if they are dissatisfied with their respective final determination of the Medicare contractor, the amount in controversy is $50,000 or more, and the providers' requests for hearing are filed within 180 days of the date of notice of their respective final determinations.

The Board denies the request for reconsideration and reinstatement. According to 42 C.F.R. § 405.1885, only matters specifically revised in the RNPRs were the adjustments related to realigning the SSI percentages from federal fiscal year to the providers' fiscal year. The Board finds that the realignment process does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[3] The total number of Part C days in the SSI fraction did not change for the providers and changes in Part C days may be simply a result of which months Part C patients were inpatients at the hospital, and not any "specific action" of the Contractor in processing the realignment.

In the realignment requests, the Providers stated, "If the Supreme Court issues a decision that upholds the *Allina* decision, CMS will be required to recalculate their SSI ratios for all affected federal fiscal years and presumably any years where SSI ratio realignments were requested, and the MA patients were included. Consistent with the aforementioned federal appellate court decision, we request the exclusion of Medicare Part C days from the SSI ratio realignment process." However, *Allina* did not change the inclusion of Part C days in the SSI fraction, so the adjustments that resulted from the requested realignment would not result in a change to the Providers' reimbursement.

The Board reaffirms its findings that the RNPRs were adjustments related to realigning the SSI percentages from the federal fiscal year to the providers' fiscal year ending. Therefore, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and

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

405.1835(a)(1) for the Part C Days issues as these issues were not specifically revised in the revised final determination. In this regard, the Board notes that Courts have upheld the Board interpretation and application of 42 C.F.R. §§ 405.1889(b).[4]

Regardless, the Board also had a separate and independent basis for dismissing the instant CIRP group since, pursuant to 42 C.F.R. § 405.1837(b)(1), Dignity Health can pursue a common issue for a particular year *in **only** one CIRP group*. Specifically, the instant CIRP group is a prohibited duplicate of Case No. 16-1121GC which entailed the ***same*** legal issue for the same year and is currently pending before the Board. In this regard, the Board note the D.C. District Court recently stated: "These appeals of revised NPRs are thus "issue-specific," a limitation designed to " 'forestall repetitive or belated litigation of stale eligibility claims.'" *HCA Health*, 27 F.3d at 620–21 (quoting *Califano v. Sanders*, 430 U.S. 99, 108, 97 S. Ct. 980, 51 L.Ed.2d 192 (1977)); *accord St. Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447, 1449 (D.C.Cir. 984)."[5]

Accordingly, the Board denies the Request for Reinstatement and Case No. 20-0770GC remains closed.

Board Members Participating:

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

For the Board:

4/5/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solution (J-E)

[4] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). *See also FirstHealth Moore Reg'l Hosp. v. Becerra*, 560 F. Supp. 3d 295 (D.D.C. 2021).

[5] *Empire Health Fndtn. v. Burwell*, 209 F. Supp. 3d 261, 271 (D.D.C. 2016) (underline emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Glenn Bunting
Moss Adams LLP
2882 Prospect Dr., Ste. 300
Rancho Cordova, CA 95670

RE: ***Denial of Motion for Reinstatement***
Case No. 20-1622GC – Dignity Health CY 2014 Medicare Part C Days in Realigned SSI Ratio CIRP

Dear Mr. Bunting,

The Provider Reimbursement Review Board ("Board") has reviewed the above referenced appeal in response to the Providers' request for reinstatement ("Motion for Reinstatement") submitted on October 9, 2023. The decision of the Board is set forth below.

Pertinent Facts:

On May 4, 2020, Moss Adams LLP ("Moss Adams") filed the "Dignity Health CY 2014 Medicare Part C Days included in CMS Realigned SSI Ratio CIRP Group" under Case No. 20-1622GC. At the time of its dismissal, the Common Issue Related Party ("CIRP") group was not designated to be fully formed and included ten participants ("Providers"):

- California Hospital Medical Center (05-0149) (RNPR)
- St. Rose Dominican Hospitals - San Martin Campus (29-0053) (RNPR)
- Mercy Hospital of Folsom (05-0414) (RNPR)
- St. Rose Dominican Hospitals - Rose De Lima Campus (29-0012) (RNPR)
- Mercy General Hospital (05-0017) (RNPR)
- Mercy Medical Center (05-0444) (RNPR)
- Mercy Medical Center Redding (05-0280) (RNPR)
- St. Bernardine Medical Center (05-0129) (RNPR)
- St Joseph's Medical Center (05-0084) (RNPR)
- St. Rose Dominican Hospitals - Siena Campus (29-0045) (RNPR)

The group appeal issue filed from receipt of revised Notices of Program Reimbursement ("RNPR") by the Providers is "Medicare DSH Payments – CMS Inclusion of Medicare Managed Care Part C Days in the Realigned SSI Ratio Determined By CMS."

On September 6, 2023, the Board issued a letter closing Case No. 20-1622GC finding that it "lacks jurisdiction over the Providers because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals. Specifically, the Board found the RNPRs were a result of SSI Realignment request and did not adjust the Part C

days issue. Therefore, did not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1). Further, the Board determined the Providers already appealed the Part C days issue for this specific fiscal year in group case 16-2569GC, Dignity Health 2014 Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group. As both group appeals were seeking to pursue the same issue, the Board determined Case No. 20-1622GC is a duplicate of Case No. 16-2569GC in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the PRRB Rules involving duplicate appeals, 4.6.1.

Providers' Request for Reconsideration

On October 9, 2023, the Providers submitted a Request for Reinstatement disagreeing with the Board's decision that it lacks jurisdiction over the appeals filed from the RNPRs. The Providers maintain that they do have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1) and request the reinstatement of Case No. 20-1622GC. The Providers maintain they have demonstrated the RNPRs for all ten Providers were "issued as a result of SSI realignment requests, and the RNPRs did adjust the number of Medicare Part C Days for each Provider participating in the group."[1]

The Providers argue that because the RNPR looks at the Provider's cost reporting year compared to the original NPR looking at the federal fiscal year, there are Medicare Part C days in the RNPR that do not overlap with the original NPR. They state that the SSI ratio datasets for the NPR and RNPR are therefore not identical, and that the original NPR dataset has been superseded by the RNPR dataset according to 42 C.F.R. § 412.106(b)(3). The Provider then states that it was jurisdictionally proper to appeal SSI ratio realignment readjustments from the RNPR because the different dataset is not covered by the appeal in Case No. 16-2569GC. Therefore, the Providers contend the appeal is not duplicative because each appeal contains different Medicare Part C days in the SSI ratios applicable to the 2014 year. Two separate Common Issue Related Party (CIRP) appeals were created from the NPRs and RNPRs issued by the MAC which cover different groups of data. As a result, it is not a "single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." The Providers state they have provided evidence that CMS has adjusted the number of Part C days for each Provider in the group according to their SSI ratio realignment request. The Providers argue that as a result they do have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

Board's Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2005), a group of providers have a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if they are dissatisfied with their respective final determination of the Medicare contractor, the amount in controversy is $50,000 or more, and the providers' requests for hearing are filed within 180 days of the date of notice of their respective final determinations.

The Board denies the request for reconsideration and reinstatement. According to 42 C.F.R. § 405.1885, only matters specifically revised in the RNPRs were the adjustments related to

[1] Provider Request for Reconsideration at 5.

realigning the SSI percentages from federal fiscal year to the providers' fiscal year. The Board finds that the realignment process does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[2] The total number of Part C days in the SSI fraction did not change for the providers and changes in Part C days may be simply a result of which months Part C patients were inpatients at the hospital, and not any "specific action" of the Contractor in processing the realignment.

In the realignment requests, the Providers stated, "If the Supreme Court issues a decision that upholds the *Allina* decision, CMS will be required to recalculate their SSI ratios for all affected federal fiscal years and presumably any years where SSI ratio realignments were requested, and the MA patients were included. Consistent with the aforementioned federal appellate court decision, we request the exclusion of Medicare Part C days from the SSI ratio realignment process." However, *Allina* did ***not*** change the inclusion of Part C days in the SSI fraction, so the adjustments that resulted from the requested realignment would not result in a change to the Providers' reimbursement.

The Board reaffirms its findings that the RNPRs were adjustments related to realigning the SSI percentages from the federal fiscal year to the providers' fiscal year ending. Therefore, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issues as these issues were not specifically revised in the revised final determination. In this regard, the Board notes that Courts have upheld the Board interpretation and application of 42 C.F.R. §§ 405.1889(b).[3]

Regardless, the Board notes that the Board would have another independent basis to dismiss these RNPR appeals because, consistent with Board Rule 4.6 and 42 C.F.R. § 405.1835(b)(1), it would be a prohibited duplicate appeal of a CIRP group already pending before the Board and Dignity Health may pursue a common issue for a particular year in ***only*** one CIRP group. Here, Dignity

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

[3] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Franciscan St. Margaret Health v. Azar*, 407 F. Supp. 3d 28 (D.D.C. 2019); *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). *See also FirstHealth Moore Reg. Hosp. v. Becerra*, 560 F. Supp. 3d 295 (D.D.C. 2021).

Health already is currently pursuing this same legal issue as part of the CIRP group under Case No. 16-2567 entitled "Dignity Health CY 2014 SSI/Medicaid Part C Days CIRP Group" and this case is still pending before the Board. In this regard, the Board note the D.C. District Court recently stated: "These appeals of revised NPRs are thus "issue-specific," a limitation designed to " 'forestall repetitive or belated litigation of stale eligibility claims.'" *HCA Health*, 27 F.3d at 620–21 (quoting *Califano v. Sanders*, 430 U.S. 99, 108, 97 S. Ct. 980, 51 L.Ed.2d 192 (1977)); *accord St. Mary of Nazareth Hosp. Ctr. v. Schweiker*, 741 F.2d 1447, 1449 (D.C. Cir. 984)."[4]

Accordingly, the Board denies the Request for Reinstatement and Case No. 20-1622GC remains closed.

Board Members Participating:

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

For the Board:

4/5/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solution (J-E)

[4] *Empire Health Fndtn. v. Burwell*, 209 F. Supp. 3d 261, 271 (D.D.C. 2016) (underline emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Andrew Ruskin, Esq.
K&L Gates LLP
1601 K Street, NW
Washington, D.C. 20006-1600

RE: ***Expedited Judicial Review Determination***
Trinity Health CY 2017 IME Calculation–Labor & Delivery Beds CIRP Group
Case No. 20-0036GC

Dear Mr. Ruskin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review ("EJR") filed on December 5, 2023 in the above-referenced common issue related party ("CIRP") group appeal. The Board's decision on jurisdiction and EJR are set forth below.

Issue:

The issue for which EJR has been requested is: Whether the Federal Fiscal Year ("FFY") 2013 regulatory change to 42 C.F.R. § 412.105(b), which removed the prior regulatory language that plainly excluded Labor & Delivery ("L&D") beds in the count of available beds used in the indirect medical education ("IME") adjustment calculation, is unlawful and therefore invalid.[1]

Statutory and Regulatory Background:

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the inpatient prospective payment system ("IPPS"). The IPPS statute contains a number of provisions that adjust payment based on hospital specific factors.[2] One of those provisions creates payment for IME. The provision at 42 U.S.C. § 1395ww(d)(5)(B) provides that teaching hospitals that have residents in approved graduate medical education ("GME") programs receive an additional payment for each Medicare discharge to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals.[3] Regulations at 42 C.F.R. § 412.105 establish how the additional payment is calculated. The additional payment, known as the IME adjustment, is calculated using the hospital's ratio of full-time equivalent ("FTE") residents to available beds. This appeal concerns the count of available beds for the IME adjustment calculation, specifically the FFY 2013 regulatory change to § 412.105(b), which removed L&D beds from the regulatory list of beds excluded from the available bed count.

[1] Providers' EJR Request at 1-3, 9-11 (Dec. 5, 2023) ("Request for EJR").
[2] *See* 42 U.S.C. § 1395ww(d)(5).
[3] *See also* Social Security Act § 1886(d)(5)(B).

The equation used to calculate the IME adjustment uses a hospital's ratio of residents to beds, which is represented as r, and a formula multiplier, which is represented as c, in the following equation: c x[{1+r{time} \.405\-1], or, it can also be written as, IME Multiplier x $[(1+r)^{0.405} -1]$.[4] Specifically, the statute at 42 U.S.C. § 1395ww(d)(5)(B) (2014) states, in pertinent part:

> (B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:
>
> (i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A),[5] by (II) the indirect teaching adjustment factor described in clause (ii).
>
> (ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) −1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. Subject to clause (ix), for discharges occurring— . . . .
>
> (XII) on or after October 1, 2007, "c" is equal to 1.35.

The formula is traditionally described in terms of a certain percentage increase in payment for every 10-percent increase in the resident-to-bed ratio.[6]

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[4] 74 Fed. Reg. 43753, 43898 (Aug. 27, 2009).

[5] This section of the statute, 42 U.S.C. § 1395ww(d)(1)(A), states, in pertinent part:

> (1)(A) Notwithstanding section 1395f(b) of this title but subject to the provisions of section 1395e of this title, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—
> (i) beginning on or after October 1, 1983, and before October 1, 1984. . . .
> (ii) beginning on or after October 1, 1984, and before October 1, 1987. . . .
> (iii) beginning on or after April 1, 1988, is equal to
> (I) the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, or
> (II) for discharges occurring during a fiscal year ending on or before September 30, 1996, ...

[6] 74 Fed. Reg. at 43898. In the FFY 2010 IPPS Final Rule, the formula multiplier, c, was changed to 1.35, which was estimated to result in an increase in IPPS payment of 5.5 percent for every approximately 10-percent increase in the hospital's resident-to-bed ratio. *Id.* The schedule of formula multipliers to be used in the calculation of the IME adjustment can be found in the regulation at 42 C.F.R. § 412.105(d)(3). *Id.*

The regulation at 42 C.F.R. § 412.105(b) provides the procedure for the determination of the number of beds for the "r" ratio in the IME adjustment factor calculation. The regulation states that the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period and dividing that number by the number of days in the cost reporting period. The count of available bed days excludes bed days associated with certain beds, as listed in the regulation, and until the FFY 2013 regulatory change, on that list of excluded beds was beds used for "ancillary labor/delivery services" at § 412.105(b)(4) (2011).[7] For purposes of the IME payment adjustment, an increase in a hospital's number of available beds results in a decrease in the resident-to-bed ratio. Thus, the FFY 2013 inclusion of bed days associated with L&D patients in the available bed count for IME will increase the available beds, decrease the resident-to-bed ratio, and, consequently, decrease IME payments to teaching hospitals.[8]

With regard to this regulatory change, CMS explains that its policy for counting hospital beds is to include bed days available for IPPS-level acute care hospital services.[9] Generally, beds would be considered available for IPPS-level acute care hospital services if the services furnished in that unit were generally payable under the IPPS.[10] Services furnished to an L&D patient are considered to be generally payable under IPPS.[11]

Significantly, to ensure consistency (as explained below), this regulatory change follows changes to policy that were made in prior years relating to the inclusion of L&D patient days in the Medicare DSH calculation.[12] Prior to FY 2010, CMS policy was to exclude from the count of inpatient days, for purposes of the Medicare DSH calculation, L&D patient days associated with beds used for ancillary L&D services when the patient did not occupy a routine bed prior to occupying an ancillary L&D bed. This policy applied whether the hospital maintained separate L&D rooms and postpartum rooms, or whether it maintained "maternity suites" in which labor, delivery, and postpartum services all occurred in the same bed. However, in the latter case, patient days were counted proportionally based on the proportion of (routine/ancillary) services furnished. In FY 2010, CMS revised regulations to include in the disproportionate patient percentage ("DPP") of the Medicare DSH payment adjustment all patient days associated with patients occupying L&D beds once the patient has been admitted to the hospital as an inpatient regardless of whether the patient days are associated with patients who occupied a routine bed prior to occupying an ancillary L&D bed. The rationale for this change was that the costs associated with L&D patient days are generally payable under the IPPS.[13]

Thereafter, CMS reexamined its policy under § 412.105(b)(4), and recognized that while the services furnished to an L&D patient are considered to be generally payable under the IPPS,

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[7] The regulatory change of now including L&D beds in the bed count, was effective for cost reporting periods beginning on or after October 1, 2012, and therefore applied to the Provider Group's cost reporting periods at issue in this case. 77 Fed. Reg. 53258, 53412 (Aug. 31, 2012); *see* Schedule of Providers, attached to this decision.
[8] 77 Fed. Reg. at 53734. CMS estimated that the inclusion of L&D beds in the available bed day count will decrease IME payments by $40 million in FY 2013. *Id.*
[9] 77 Fed. Reg. at 53411.
[10] *Id.*
[11] *Id.*, citing 74 Fed. Reg. at 43900 (the FY 2010 IPPS/RY 2010 LTCH PPS Final Rule).
[12] 77 Fed. Reg. at 53411.
[13] *Id.*

under that regulatory provision, the bed where the services are furnished is not considered to be available for IPPS-level acute care hospital services.[14] CMS determined that if a patient day is counted because the services furnished are generally payable under the IPPS, then the bed in which the services were furnished should also be considered to be available for IPPS-level acute care hospital services. Accordingly, CMS found it was appropriate to extend its current approach of including L&D patient days in the DPP of the Medicare DSH payment adjustment to its rules for counting hospital beds for purposes of both the IME payment adjustment and the Medicare DSH payment adjustment.[15] CMS' intention was to align its patient day and bed day policies.[16] The rules for counting hospital beds for purposes of the IME payment adjustment, codified at § 412.105(b), are cross-referenced in § 412.106(a)(1)(i) for purposes of determining the DSH payment adjustment. CMS explains as follows:

> In light of the similar policy rationales for determining patient days in the calculation of the Medicare DSH payment adjustment, and for determining bed days for both the Medicare DSH payment adjustment and the IME payment adjustment, [CMS] proposed to include labor and delivery bed days in the count of available beds used in the IME and DSH calculations. Moreover, [CMS] stated that our proposal to treat labor and delivery patient days and bed days the same is consistent with our approach with respect to the observation, swing-bed, and hospice days, which are excluded from both the patient day count and the available bed count. Accordingly, [CMS] proposed to revise the regulations at § 412.105(b)(4) to remove from the list of currently excluded beds those beds associated with "ancillary labor/delivery services.[17]

While a number of commenters to the proposed rule stated that the current discrepancy in the treatment of L&D for purposes of the patient day count and the bed day count is appropriate because L&D services are typically not paid for by the Medicare program, which only pays for one percent of all births in the United States, CMS responded that whether the volume of L&D services paid by Medicare is as low as asserted by the commenters, it does not alter the fact that patients receiving these services are inpatients who are receiving an IPPS-level of care whether or not paid under the Medicare program.[18] CMS explained that a policy to exclude beds from a hospital's number of available beds based on the volume of services paid for by Medicare would create unpredictability with respect to DSH and IME payment adjustments and could impose an undue burden on the agency and hospitals to monitor the volume of individual services to determine appropriate exclusions.[19]

Commenters further pointed to the fact that the policy with respect to nursery days has this discrepancy in which patient stays are included in the patient day count for purposes of the DSH

[14] *Id.* at 53412.
[15] *Id.*
[16] *Id.* at 53413.
[17] *Id.* at 53412.
[18] *Id.*
[19] *Id.*

calculation but are excluded from the DSH and IME bed counts, which they indicated is appropriate, and that it would be appropriate to take a similar approach with L&D days. However, CMS responded that while it appreciated the commenters pointing out this potential discrepancy, it would consider addressing the issue in future rulemaking.[20]

In summary, CMS adopted its proposed policy and removed from the list of excluded beds in § 412.105(b)(4), those beds associated with "ancillary labor/delivery services."[21]

Providers' Position:

The Providers are requesting that the Board grant EJR as to the validity of the regulation at 42 C.F.R. § 412.105(b) implementing the FFY 2013 regulatory change to now include L&D beds in the IME bed count.[22] The Providers assert that granting EJR in this case is appropriate because the Providers are directly challenging the regulation that governs the list of beds that are excluded from the IME available bed count.[23] Specifically, that regulation, 42 C.F.R. § 412.105(b), no longer expressly excludes L&D beds from the available bed count, even though the IME formula memorialized at 42 U.S.C. § 1395ww(d)(5)(B)(ii) is based on data that excludes these beds.[24]

The Providers explain that central to the IME calculation is the interns and residents to beds ratio (the "IRB Ratio"), which is a measure of teaching intensity. The IME formula uses the IRB Ratio as a statistic that explains the increased costs that teaching hospitals incur in treating their Medicare patients, as compared with non-teaching hospitals. The IRB Ratio has a curvilinear relationship to increased costs, and the IME formula delineates that correlation, based on data available when the statute was enacted. At the time of the statute's enactment, L&D beds were expressly carved out from hospital bed counts for Medicare purposes. Therefore, the inclusion of these beds now undermines the integrity of the data-driven calculation carefully crafted by Congress. In other words, the term "bed" as used in the statutory description of the IRB Ratio must have a consistent meaning for the formula to work. The revision to the regulation contravenes that meaning, and the Providers contend that it is therefore unlawful.[25]

The Providers assert that the Medicare program has offered no support as to how a ratio that includes the L&D beds better explains the increased costs teaching hospitals incur in treating Medicare patients.[26] The Providers assert that CMS mistakenly extrapolated the policy of excluding L&D days from the DSH calculation of inpatient days to the entirely unrelated IME calculation.[27] The Providers contend that implicit in CMS' reasoning for its decision, is the concept that the IRB Ratio bed count is based off of the number of beds available for services reimbursed under IPPS.[28] However, CMS does not explain how it arrived at that conclusion. The

[20] *Id.*
[21] *Id.* at 53412.
[22] Request for EJR at 1-2 (*citing* 42 U.S.C. §§ 1395oo(f)(1); 42 C.F.R. § 405.1842(f)).
[23] *Id.* at 2.
[24] *Id.* at 2-3.
[25] *Id.* at 3.
[26] *Id.*
[27] *Id.* at 8.
[28] *Id.*

Providers assert that the statute requires the IRB Ratio bed count to be based on the methodology that CMS used to count beds in 1983.[29] While it may very well be that services to patients in these L&D beds could qualify, if they are Medicare beneficiaries, for reimbursement under IPPS, nowhere in the statute or the legislative history is that held out as a test for inclusion in the IRB Ratio bed count.[30] The Providers note that the IRB Ratio originated in a 1980 Federal Register that preceded the inception of the IPPS program in 1983, and that routine cost limitations, not IPPS, was in effect in 1983, the date specified in the statute. It would therefore be impossible for IPPS payment for services to patients in a particular bed to be the litmus test of inclusion in the IRB Ratio bed count.[31]

The Providers assert CMS' regulatory change is unlawful and must be overturned for four main reasons. First, it violates the plain meaning of the statute, which expressly states that the methodology to be followed for the IME calculation is the one that the Medicare program used in 1983 that excluded L&D beds as "ancillary." In terms of the delegation of authority to CMS by statute, CMS is not empowered to change the definition of bed.[32]

Second, it violates the statute's manifest intent. The stated purpose of the statute is to address patient costs that teaching hospitals incur indirectly relating to their teaching activities, as indicated by the IRB Ratio serving as a measure of the teaching industry. The use of the 0.405 teaching factor expresses a very precise curvilinear relationship based on empirical findings using defined variables. Definitional changes to those variables undermine the integrity of the whole formula. L&D beds were excluded from the bed count in the data sets relied on in setting the teaching factor.[33]

Third, it is otherwise arbitrary and capricious in that the agency has not articulated a satisfactory explanation for its action, including a rational connection between the facts found and the choice made. CMS has not indicated how the inclusion of L&D beds better reflects the methodology used by the Medicare program in 1983, or how it better correlates the resulting teaching intensity calculation to the undercompensated teaching hospital operating costs. The Providers note that it is as if CMS has simply forgotten that that the DSH calculation and the IME calculation are governed by different statutes, and that loyalty to both is required; the consistency in the definition of beds across the statutes must be a secondary concern.[34]

Fourth, it treats similar situations differently without sufficient explanation. The Medicare program has historically considered L&D beds to be ancillary beds, and in that way, they are like recovery beds. Patients in a recovery bed may be in an IPPS level stay, and yet those beds remain excluded. CMS has not explained how these two types of beds are different in a way that justifies the differences in their treatment, and agencies are not allowed to treat similarly situated circumstances differently without sufficient justification.[35]

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[29] *Id.*
[30] *Id.*
[31] *Id.*
[32] *Id.* at 9.
[33] *Id.*
[34] *Id.* at 10.
[35] *Id.*

Decision of the Board:

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

A. Jurisdiction and Claim-Filing Requirements for a Board Hearing[36]

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[37] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[38] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. Part 405, Subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in this group case have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise the group appeal have filed appeals involving fiscal years ending in 2017. All the participants have appealed from an original NPR. Based on its review of the record, the Board finds that all the providers in the group appeal filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835. The Providers each appealed the issue in the Request for EJR, and the Board is not precluded by regulation or statute from reviewing the issue. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R.

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[36] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim-filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim-filing requirements.

[37] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).

[38] *Id.* at 70555.

§ 405.1837(a)(3) in the cases at issue. Therefore, the Board finds that it has jurisdiction over the Providers and that they met the claim-filing requirements for a Board hearing.[39]

B. Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016)

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, § 413.24(j), specifies that, in order for a specific item to be eligible for potential reimbursement, the provider must include an appropriate cost report claim for that specific item:

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

[39] *See supra* note 36.

> provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) addresses when the Board must examine a provider's compliance with § 413.24(j):

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.[40]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[41] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[42]

Board Rule 44.5.2 governs the timing for filing substantive claim challenges pursuant to 42 C.F.R. § 405.1873(a) and reads:

> A party that questions whether the one or more participants in a group case (CIRP or optional) included an appropriate claim *on the cost report at issue* for the common issue being appealed in the group must file a Substantive Claim Challenge sixty (60) days after the group files its final Schedule of Providers (SOP) unless the moving party's filing demonstrates good cause.[43] The moving party

[40] (Bold and underline emphasis added.)
[41] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[42] *See* 42 C.F.R. § 405.1873(a).
[43] (Italics and bold emphasis in original and underline emphasis added.)

> must summarize in its Substantive Claim Challenge the efforts that it made to contact the opposing party to discuss the merits of the Substantive Claim Challenge. If the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made. *See* sample language in Rule 44.2. The opposing party(ies) has thirty (30) days to respond (including in the context of an EJR filing).
>
> - *Expedited Challenge Filing Deadline When an EJR Request Is Filed per Board Rule 42*.---<u>If the final SOP is filed concurrent with an EJR request or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then refer to Rule 44.6 for special instructions on deadlines for filing Substantive Claim Challenges and any response thereto</u>**.**
>
> Following the completion of the parties' briefing, the Board will issue its findings and legal conclusions on the Substantive Claim Challenge based on the record ***unless*** a party requests otherwise by motion (*e.g.*, requests additional time to submit evidence, requests a hearing to present argument and evidence) ***and*** the Board grants leave for additional filings and/or proceedings.[44]

The Board also issued special rules for filing jurisdictional or substantive claim challenges in group cases when an EJR request is filed within 60 days of the final schedule of providers and those are located in Board Rule 44.6 (v. 3.1, 2021):

> If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) has five (5) business days to either:
>
> 1. File any jurisdictional and/or Substantive Claim Challenge(s) related to the group appeal (or participants therein, as relevant); or
>
> 2. Submit a filing wherein the Medicare contractor certifies that it will, *in fact*, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).
>
> If the Medicare contractor files the certification described above in No. 2, then the Medicare contractor must file the challenge(s) ***no later than twenty (20) days following the filing of the EJR request***.

[44] (Emphasis added.)

> Following receipt of those challenges (and consistent with 42 C.F.R. §§ 405.1842(e)(3), 405.1873(b)(1), and 405.1873(d)(2) and Board Rule 42.1), the Board will issue a Scheduling Order setting a deadline for the Provider's response and will confirm therein that the 30-day period for the Board to rule on the EJR request has been stayed because the EJR request is incomplete and the Board does not yet have all the information necessary to rule on the EJR request.[45]

1. Substantive Claim Challenges

This CIRP group was fully formed on October 20, 2023, and the Request for EJR was filed on December 5, 2023. Pursuant to Board Rule 44.6, on December 12, 2023, the Medicare Contractor filed a timely certification that it would be filing a Substantive Claim Challenge in this case.

On December 13, 2023, the Board issued a Scheduling Order for filing any Substantive Claim Challenges and responses thereto. This Scheduling Order confirmed that the Board needed additional information from the parties before ruling on the Request for EJR. As a result, the Board informed the parties that it had not completed its review of jurisdiction and related claims-filing requirements and, as a result of the Scheduling Order, the 30-day period for the Board to respond to the Request for EJR had not yet begun.[46]

On December 22, 2023, the Medicare Contractor filed a Substantive Claim Challenge over five (5) of the eighteen (18) participants in this CIRP Group:

1. Saint Alphonsus Regional Medical Center (Prov. No. 13-0007, FYE 06/30/2017)
2. Loyola University Medical Center (Prov. No. 14-0276, FYE 06/30/2017)
3. Holy Cross Hospital (Prov. No. 10-0073, FYE 06/30/2017)
4. St. Francis Hospital (Prov. No. 08-0003, FYE 06/30/2017)
5. Our Lady of Lourdes Medical Center (Prov. No. 31-0029, FYE 06/30/2017)

For each participant, the Medicare Contractor argued that they have "not claimed reimbursement for an amount purportedly stemming from the IME Available Bed Count issue." It also noted that, for each participant, they "did include a Summary of Protested Amounts reporting [a specific amount in controversy] for the IME Available Bed Count issue, however, the Provider did not include specific calculations that described how the Provider calculated the estimated reimbursement amount for that issue."

On January 12, 2024, Group Representative filed a Response to the Medicare Contractor's Substantive Claim Challenges. He provided Declarations and exhibits to show that detailed calculations, as well as explanations of the L&D Days issue, were submitted with the applicable cost reports, or that detailed explanations were not requested from the Medicare Contractor. He

[45] (Emphasis in original.)
[46] *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii). *See also Saint Francis v. Becerra*, No. 22-cv-1960, 2023 WL 6294168 (D.D.C. Sept. 27, 2023) (for example stating at *5: "The first sentence of § 405.1842(e)(1) fixes when the thirty-date period for determining authority defined in the second sentence becomes operative, specifically, after the Board determines it has jurisdiction." (citation omitted)).

also raised objections to the validity of any Substantive Claim requirements at all based on *Bethesda Hosp. Ass'n v. Bowen*[47] and *Banner Heart Hospital v. Burwell*.[48][49]

On February 7, 2024, the Board issued a Request for Information,[50] requiring each party to respond to the following questions:

1. Per your records, how was the cost report and its supporting documentation (including any protested items) originally filed with the Medicare Contractor? For example, was it submitted using a CD, Flash Drive, and/or in a hard copy? Be specific.

2. Describe the composition of the protested items support included with the as-filed cost report. Be specific. For example, was it a single file versus separate files for each calculation? Was it in Excel format, with or without multiple tabs, or was it in a PDF, Word or another format?

3. Provide all correspondence that the participant sent to the Medicare Contractor, as part of its cost report submission including any cover letter, which may have described the contents enclosed with the participant's cost reporting submission.

4. Provide the cost report acceptance checklist or log used in the Medicare Contractor's review of the participant's cost report submission (note the Medicare Contractor is likely the only party to respond to this request).

5. Provide a copy of the complete as-filed cost report submission that was retained (by either party) as a business record and describe the organization's practice/process by which it retained that copy as a business record.

6. Explain:

   (a) how your submission (as supplemented in response to this RFI) addresses the participant's claimed compliance with the requirements of 42 C.F.R. 413.24(j)(2), which includes the requirement to "[a]ttach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing

[47] 485 U.S. 399 (1988).
[48] 201 F.Supp.3d 131 (D.D.C. 2016)
[49] Response to MAC Substantive Claim Letter, 5-7 (Jan. 12, 2024).
[50] The Board reminded the parties that its December 13, 2023 Scheduling Order explained it had not yet completed its jurisdictional and substantive claim review and the 30-day period for Board review of the Request for EJR had still not yet begun. The Board confirmed in its February 7, 2024 Request for Information that this stay of the 30-day period remained in effect.

how the provider calculated the estimated reimbursement amount for each specific self-disallowed item"; and

(b) Whether an exception under 42 C.F.R. 413.24(j)(3) applies to the participant and, if so, how it applies, including how it may impact the participant's 413.24(j)(2) obligations.

On February 14, 2024, the Board issued a Clarification for question 5:

(a) Question 5 encompasses, as relevant, any amended cost report accepted by the Medicare Contractor for the fiscal year at issue.

(b) The copy should exclude any supporting files containing protected health information ("PHI"). To the extent any supporting files are excluded, identify each supporting file that is excluded. NOTE—the Board has asked for a copy of the cost report/amended cost report filing (as opposed to a listing of the documents/files that were submitted by the Provider as part of that filing).

Both parties filed responses to the Board's Request for Information ("RFI") on March 8, 2024.

In its response, The Medicare Contractor rescinded its Substantive Claim Challenges for three of the originally challenged participants and, thereby, conceded that the following participants met the substantive claim requirements in 42 C.F.R. § 413.24(j):

1. Holy Cross Hospital (Prov. No. 10-0073, FYE 06/30/2017);
2. St. Francis Hospital (Prov. No. 08-0003, FYE 06/30/2017); and
3. Our Lady of Lourdes Medical Center (Prov. No. 31-0029, FYE 06/30/2017).

It noted, however, that it is still pursuing a Substantive Claim Challenge for the following two participants:

1. Saint Alphonsus Regional Medical Center (Prov. No. 13-0007, FYE 06/30/2017) ("St. Alphonsus"); and
2. Loyola University Medical Center (Prov. No. 14-0276, FYE 06/30/2017) ("Loyola").

Both parties replied to the questions posed in the Board's RFI[51] and submitted letters and workpapers as exhibits related to the cost reports at issue. The Medicare Contractor continues to maintain that, for St. Alphonsus and Loyola, the as-filed cost report submissions did not contain a detailed explanation or worksheet to show ***how*** the participants calculated their estimated impact for the disallowed IME item as required by 42 C.F.R. § 413.24(j)(2)(ii).

The Group Representative asserts that, for Loyola, a "detailed: narrative of the issue was included in the transmittal letter with the cost report. Based on this "detailed" narrative and the

[51] The Board notes that the Provider did not reply to questions 6.a or 6.b in its Response.

estimated amount in controversy, the Group Representative argues that "[e]ven if there was not an exact line by line calculation worksheet, it is self-explanatory that the calculation involves computing the difference between including and excluding these beds on Worksheet E, Part A. The final amount is the result of the flow-through originating with that one change to the data input."[52] The Group Representative also claims that the protested items PDF that Loyola submitted with the cost report was created from an Excel sheet, which had additional tabs that were **not** actually included with the cost report submission; but the PDF did have a summary page with the amount in controversy for the IME issue listed.[53]

For St. Alphonsus, the Group Representative said there is nothing new to add beyond what was said in its initial Substantive Claim Challenge Response.[54] He provided an estimate of the amount at issue and described the issue related to counting and including ancillary labor and delivery beds, which is sufficient to satisfy the requirements of 42 C.F.R. § 413.24(j)(2).[55]

C. Board's Analysis of the Remaining Substantive Claim Challenges

As an initial matter, the Board notes that thirteen (13) of the eighteen (18) participants in this CIRP group do not have any Substantive Claim Challenges pending.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[56] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[57] In this CIRP group case, the Medicare Contractor failed to file a Substantive Claim Challenge[58] within the time frame specified by Board Rule 44.5.1 (2021) for thirteen (13) participants. For these 13 participants, the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made by each of these 13 participants.[59] As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered and the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for these thirteen (13) participants.

For the remaining 5 participants, the Medicare Contractor did trigger § 405.1873(a) by filing Substantive Challenges for these 5 participants. Specifically, for , the Medicare Contractor filed

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[52] Provider's Response to Request for Information at 2 (Mar. 8, 2024).
[53] *Id.* at 3, ¶ 2.
[54] *Id.* at 4.
[55] Response to MAC Substantive Claim Letter, 5 (Jan. 12, 2024).
[56] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[57] *See* 42 C.F.R. § 405.1873(a).
[58] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[59] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

Substantive Claim Challenges for the following three participants but then later rescinded the challenges for those three (3) additional participants, thereby conceding that they met the § 413.24(j) substantive claim requirements:

1. Holy Cross Hospital (Prov. No. 10-0073, FYE 06/30/2017);
2. St. Francis Hospital (Prov. No. 08-0003, FYE 06/30/2017); and
3. Our Lady of Lourdes Medical Center (Prov. No. 31-0029, FYE 06/30/2017).

As a result, it is now undisputed that these 3 participants met the substantive claim filing requirements in § 413.24(j). Accordingly, the Board finds that these 3 participants met those substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d) for these three (3) participants.

The only remaining Providers with Substantive Claim Challenges pending are Loyola and St. Alphonsus. Regarding Loyola and St. Alphonsus, as pointed out by the Medicare Contractor, 42 C.F.R. § 413.24(j)(2) specifies that a provider must follow the following procedure for self-disallowing a specific item:

> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) ***Attach a separate work sheet*** *to the provider's cost report for* ***each*** *specific self-disallowed item,* explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and ***describing how*** *the provider calculated the estimated reimbursement amount for* ***each*** *specific self-disallowed item.*[60]

The Medicare Contractor is claiming that the as-filed cost reports for Loyola and St. Alphonsus did not include enough detail on how the reimbursement impact of these self-disallowed items was calculated. It is claiming that listing an amount in controversy and a description of how the issue generally impacts reimbursement is insufficient.

The Group Representative claims that an amount in controversy and a detailed narrative of the issue is generally sufficient to comply with 42 C.F.R. § 413.24(j)(2). He also argues that this particular issue is "self-explanatory" and merely involves computing the difference between including and excluding these beds on Worksheet E, Part A.

The Board has reviewed the record, including the as-filed cost reports and other exhibits submitted by the Parties in response to the Board's RFI, and agrees with the Medicare Contractor finding that Loyola and St. Alphonsus have both failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1).

[60] (Emphasis added.)

For Loyola, the Parties agree that no support for the calculations of the protested item related to L&D days in the amount of $689,670 was submitted with the as-filed cost report, only the narrative: "[IME] adjustment impact of including L&D beds in available bed count." However, it is clear that the Provider failed to "***describe[e] <u>how</u>*** *the provider calculated the estimated reimbursement amount*" of $689,670.[61]

For St. Alphonsus, the Group Representative's argument is not convincing as it is clear that there was not a description of how the estimate was calculated, but rather just an estimated amount and the vague statement of "Understatement of IME payments due to inclusion of ancillary labor and delivery beds." Indeed, upon scrutiny ***<u>and</u>*** *the added information of the description of the legal issue appealed to the Board in this case*, the alleged calculation at Exhibit C-9 which results in the $16,822 amount in controversy appears to be itself incorrect because it uses actual patient days to calculate beds for the IME calculation, while the proper cost report handling is to use *available* bed days. A reconciliation to the as-filed cost report would indicate that the Provider's calculations were incorrect for the filed amount, thus the variance from their revised calculation is also incorrect.

St. Alphonsus' errors highlight why there is a requirement at 42 C.F.R. § 413.24(j)(2)(ii) that the provider self-disallowing an item attach *a separate worksheet* to its as-filed cost report for *each* specific self-disallowed item, both (1) "explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item)" and (2) "***describing <u>how</u>*** *the provider calculated the estimated reimbursement amount for* ***each*** *specific self-disallowed item*."

D. Board's Analysis of the Appealed Issue

The Providers are challenging the validity of the FFY 2013 change to 42 C.F.R. § 412.105(b), which removed the exclusion of L&D beds from the bed count determination in the procedure for carrying out the IME calculation. The Providers contend that this regulatory change is inconsistent with the enabling statute, 42 U.S.C. § 1395WW(d)(5)(B)(ii), which outlines the formula for the IME adjustment calculation, and was originally, at the time of enactment, based on data that excludes the L&D beds. The Providers maintain that the statute requires that the bed count in the IME calculation is to be based on the methodology that CMS used to count beds *in 1983*, which excluded L&D beds at that time. The Providers allege that CMS mistakenly extrapolated its policy change to include L&D beds in its DSH calculation of inpatient days, to the entirely unrelated IME calculation, and the definitional change to the bed count variable undermines the integrity of the whole IME formula to determine the costs that teaching hospitals incur indirectly relating to their teaching activities.

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply all the provisions of Title XVIII of the Act and regulations issued thereunder, including the challenged regulation, 42 C.F.R. § 412.105(b), as revised effective FFY 2013. Moreover, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant

[61] (Emphasis added.) The Board recognizes that the Group Representative also points to the cover letter to the as-filed cost report. However, it too fails to include sufficient information and it is not the requisite worksheet specified in 42 C.F.R. § 412.24(j)(2)(ii).

an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

As described above, the Board has jurisdiction to conduct a hearing on the specific matter at issue. However, the Board concludes that it lacks the authority to grant the relief sought by the Providers, *i.e.,* to reverse or otherwise invalidate the FFY 2013 modification to 42 C.F.R. § 412.105(b) that removed L&D beds from the list of beds excluded in the bed count determination. Consequently, the Board hereby grants the Providers' request for EJR for the issue and year under dispute.

Additionally, the Board recognizes that, in responding to the Medicare Contractor's Substantive Claim Challenges, the Providers have challenged the validity of 42 C.F.R. §§ 413.24(j) and 405.1873.[62] Based on the Board's findings that Loyola and St. Alphonsus have failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1), the Board finds it is appropriate to grant EJR over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 in addition to the FFY 2013 change to 42 C.F.R. § 412.105(b) for these two Providers, as well.

Board's Decision Regarding the EJR Request:

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that all of the participants in the group appeal are entitled to a hearing before the Board;

2) The review process in 42 C.F.R. § 405.1873(a)-(b) has been triggered for 5 participants in the group and the Board makes the following findings:

   a. As a result of the Medicare Contractor's rescinding of its Substantive Claim Challenge for Holy Cross Hospital (Prov. No. 10-0073, FYE 06/30/2017), St. Francis Hospital (Prov. No. 08-0003, FYE 06/30/2017), and Our Lady of Lourdes Medical Center (Prov. No. 31-0029, FYE 06/30/2017), it is undisputed that these 3 participants included "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1);

   b. Loyola University Medical Center (Prov. No. 14-0276, FYE 06/30/2017) failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1);

[62] Response to MAC Substantive Claim Letter, 5-7 (Jan. 12, 2024).

c. Saint Alphonsus Regional Medical Center (Prov. No. 13-0007, FYE 06/30/2017) failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1);

3) The review process in 42 C.F.R. § 405.1873(a)-(b) has not been triggered for the remaining thirteen (13) Providers, and therefore, there are no findings regarding whether the Providers' cost reports included appropriate claims for the specific item at issue in this appeal;

4) Based upon the Providers' assertions regarding 42 C.F.R. § 412.105(b), there are no findings of fact for resolution by the Board;

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

6) It is without the authority to decide the legal questions of:

a. Whether the FFY 2013 modification to 42 C.F.R. § 412.105(b) with regard to L&D beds is valid; and

b. For the participants, Loyola University Medical Center (Prov. No. 14-0276, FYE 06/30/2017) and Saint Alphonsus Regional Medical Center (Prov. No. 13-0007, FYE 06/30/2017), whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[63]

Accordingly, the Board finds that the question of the validity of the FFY 2013 change to 42 C.F.R. § 412.105(b) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants Loyola University Medical Center's (Prov. No. 14-0276, FYE 06/30/2017) and Saint Alphonsus Regional Medical Center's (Prov. No. 13-0007, FYE 06/30/2017) requests for EJR for the issue and the subject year.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional determination is subject to review 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

[63] The Board recognizes that this question relates only to 2 of the 18 participants in this group and, as such, does not apply to the full group. As a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to review under 42 C.F.R. § 405.1840 of jurisdictional or claims-filing requirements (*see supra* note 36), a provider's compliance with § 413.24(j) relates to the nature of the provider's *participation* in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) *as a procedural matter in the proceedings before the Board*, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Judicial review remains available on appeal for these discreet group participation issues regardless of whether they relate the jurisdiction or claims-filing requirements under § 405.1840 or the substantive claims requirements under § 413.24(j).

appeal. Since this is the only issue under dispute in this group case, the Board hereby closes the case and removes it from the Board's docket.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

FOR THE BOARD:

4/5/2024

X Clayton J. Nix

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

Enclosure:

Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

Byron Lamprecht
WPS Government Health Administrators (J-5)
1000 N. 90th Street, Suite 302
Omaha, NE 68114-2708

RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Heart of Florida Regional Medical Center (Provider Number 10-0137)
FYE: 06/30/2018
Case Number: 22-0392

Dear Mr. Summar 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. 22-0392*

On July 20, 2021, the Provider, Heart of Florida Regional Medical Center, was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On January 11, 2022, the Board received the Provider's individual appeal request. The Appeal included five (5) issues:

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

As the Provider is commonly owned/controlled by the health care chain, Community Health Services ("CHS"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). Accordingly, on August 15, 2022, the Provider transferred Issues 2, 4 and 5 to CHS CIRP groups. As a result of these transfers, the sole remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage (Provider Specific) issue) and Issue 3 (the DSH – Medicaid Eligible Days issue).

[1] On August 15, 2022, this issue was transferred to Case No. 21-1206GC.
[2] On August 15, 2022, this issue was transferred to Case No. 20-2149GC.
[3] On August 15, 2022, this issue was transferred to Case No. 21-0066GC.

On August 24, 2022, the Provider filed its preliminary position paper.

On October 7, 2022, the Medicare filed a Jurisdictional Challenge requesting that the Board dismiss Issues 1 and 3. The Provider failed to respond to the Jurisdictional Challenge within the 30-day period allowed under Board Rule 44.4.3 which states:

> Provider 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 November 23, 2022, the Medicare Contractor filed its preliminary position paper.

On January 12, 2023, the Medicare Contractor filed a copy of its request to the Provider for Eligible Days Documentation.

To date, the Provider has not submitted a listing of Redacted Medicaid Eligible Days.

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

In its 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.[4]

As the Provider is commonly owned by CHS, the Provider transferred its Issue – DSH SSI Percentage – to the CIRP group under Case No. 21-1206GC on August 15, 2022. The group issue in Case No. 21-1206GC reads, in part:

[4] Issue Statement at 1 (Jan. 11, 2022).

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)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $41,588.

On August 24, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).

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

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

In its October 7, 2022 Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for three reasons. The MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. 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 [P]rovider has not exhausted

[6] Provider's Preliminary Position Paper at 8-9 (Aug. 24, 2022).

> 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 Payment/SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue, which has been transferred to PRRB Case No. 21-1206GC, are considered the same issue by the Board, which is in violation of PRRB Rule 4.6, and should be dismissed.[8]

Lastly, the MAC contends that Issue 1 should be dismissed because the Provider failed to file a complete 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.[9]

Issue 5 – DSH Payment – Medicaid Eligible Days

In its October 7, 2022 Jurisdictional Challenge, the MAC argued that the Provider abandoned Issue 5, the DSH – Medicaid Eligible Days issue, "because it has not submitted a list of additional Medicaid days and has not fully addressed the issue in its preliminary position paper,"[10] in violation of Board Rule 25.3. Specifically, the MAC states that the Provider:

> failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim. . .
>
> ***
>
> neglected to include all supporting documentation in support, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. . . .
>
> ***
>
> makes the broad allegation, '…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….' 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. . . .
>
> ***

[7] Jurisdictional Challenge at 6-7 (October 7, 2022).
[8] *Id*. at 4-6.
[9] *Id*. at 7-9.
[10] *Id.* at 10.

> has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. . . .
>
> ***
>
> has essentially abandoned the issue by failing to properly develop its arguments[.][11]

2. Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 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 (2021), 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[13] has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

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[11] *Id.* at 10-12.
[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[13] The Board notes that the Statement of Issues lists the SSI Percentage issue as Issue #1 and the Eligible Days issue as Issue #2, although the Provider's Position briefs the Eligible Days issue first. The Board will refer to the SSI Provider Specific issue as 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. 21-1206GC.

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."[14] 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)."[15] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH – SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC 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. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH – SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 21-1206GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

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[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 3.1 (Nov. 2021).
[18] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable*, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, 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.[19]

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,

[19] Emphasis added.

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [20]

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."[21]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, *based on the record before it*,[22] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue. As stated above, 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 Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH – SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate that

[20] Last accessed April 5, 2024.
[21] Emphasis added.
[22] Again, the Provider failed to respond to the jurisdictional challenge pertaining to these issues. Accordingly, consistent with Board Rule 44.4.3, the Board must base its decision based on the record before it.

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:

> **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.[23]

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. In the preliminary position paper, the Provider states, "[b]ased on the Listing of Medicaid Eligible days bring [sic] *sent under separate cover*, the Provider contends that the total number of days reflected in its' 2018 cost report does not reflect an accurate number of Medicaid eligible days."[24]

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

[23] Individual Appeal Request, Issue 3.
[24] Provider's Preliminary Position Paper at 8 (Aug. 24, 2022) (italics emphasis added).

> payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

In this case, 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 list of Medicaid eligible days at issue under separate cover. But it failed to do so. Accordingly, it is clear that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[25]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[26]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Availability of Issue-Related Information and Basis for Dissatisfaction) (Nov. 2021) states:

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

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[25] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019, *available at:* https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2019-through-11-30-2019.pdf), 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).

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

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

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

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

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

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

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

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

> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned,

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

> • upon failure of the provider or group to comply with Board procedures,
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. The Provider is incorrect if it believes it can file its listing with the final position paper since the Rules and regulations cited above regarding position papers were in effect well before January, 2022. Moreover, the Provider appears to be well aware of the revised rules since it complied with those changes and filed its 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 it*, 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 in its position paper any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2.

The Board finds Provider neglected to explain why it failed to include this information or to explain why this information was not available when it filed its preliminary position paper. The fact that the Provider suggested a listing would be sent under separate cover, more than a year and a half ago when it filed its preliminary position paper on August 24, 2022, implied a listing was imminent. 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). 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.

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.

Finally, Board finds that the Provider has *not* attempted to cure this defect since the record before the Board still does not contain a listing of the Medicaid eligible days at issue or even the specific number of days at issue notwithstanding the fact that the fiscal year at issue closed more than 5 years ago.[31]

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[30] (Emphasis added).

[31] 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.

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. The Board takes administrative notice that it has made similar dismissals in other cases for which CHS was the designated representative.[32] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Jurisdictional Challenge.

****

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. 21-1206GC 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 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. 22-0392 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/8/2024

X Kevin D. Smith, CPA

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

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

[32] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop B1-01-31 100
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

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

Mr. John Bloom
Noridian Healthcare Solutions (J-F)
P.O. Box 6722
Fargo, ND 58108-6722

RE: ***Determination on Reopening of Fully Formed CIRP Group & Consolidation Request***

HonorHealth CY 2017 DSH SSI & MCD Fractions - Dual Eligible Days CIRP Group
Case Number: 23-0219GC

HonorHealth CYs 2016 & 2017 DSH SSI/Medicaid Dual Eligible Days CIRP Group
Case Number: 21-1685GC

Dear Mr. Ravindran and Mr. Bloom:

The Provider Reimbursement Review Board ("Board") has reviewed the January 4, 2024 correspondence from Quality Reimbursement Services, Inc. ("QRS") requesting a consolidation of the subject Dual Eligible Days common issue related party ("CIRP") group appeals. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **September 8, 2021**, QRS filed the "HonorHealth CY 2017 DSH SSI/Medicaid Dual Eligible Days CIRP Group" under Case 21-1685GC. The group, which *is not yet fully formed*, currently includes 2 providers: Deer Valley Medical Center (Provider Number 03-0092) for calendar year ("CY") 2017 and John C. Lincoln Medical Center (Prov. No. 03-0014) for CY 2016.[1]

On **November 11, 2022**, QRS filed the "HonorHealth CY 2017 DSH SSI & MCD Fractions - Dual Eligible Days CIRP Group" under Case 23-0219GC. The group, which was *designated to be fully formed on November 13, 2023*, includes two participants: John C. Lincoln Medical Center (Prov. No. 03-0014), which is the same participant in Case No. 21-1685GC for FY 2016) and Scottsdale Osborn Medical Center (Prov. No. 03-0038).

On **January 4, 2024** QRS filed a request to consolidate Case Nos. 21-1685GC and 23-0219GC under the contention that the groups are duplicates. According to QRS, " . . . PRRB Case No. 21-1685GC originally approached the DSH Dual Eligible Days issue from a much broader perspective . . .". However, QRS now contends that, " . . . in light of the Supreme Court decision

[1] On 9/29/2022, the Board expanded the CY 2017 group, Case No. 21-1685GC, to include CY 2016 to allow the consolidation of a single participant CIRP group, Case No. 21-1614GC.

in "Empire"[2], PRRB Case No. 21-1685GC will now only be pursuing the Improper Rule Making Component of the Dual Eligible Days issue. Therefore, QRS is requesting the Board reopen the status of Case No. 23-0219GC and expand the group to include CY 2016 to allow the consolidation of the two providers currently pending in Case No. 21-1685GC.

Board Determination:

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

As the Parties are aware, it is the Board's policy to establish ***only*** one (1) CIRP group appeal per issue per fiscal year end.[3] In fact, the certification page of a group appeal request includes a statement that the Representative certifies ". . . the group issue filed . . . is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn or dismissed from any other PRRB appeal."[4]

After a review of the group issue statements in Case Nos. 21-1685GC and 23-0219GC, the Board **denies** QRS' request to reopen the status of, and expand the CY 2017 group under Case No. 23-0219GC to include CY 2016, in order to allow the consolidation of Case No. 21-1685GC. Although the *Issue Title* in both groups references both the SSI and Medicaid fractions of the Dual Eligible Days issue, the Board finds that the actual issue descriptions included under the *Statement of Issue* and *Statement of the Legal Basis* in each group are NOT the same. In Case No. 21-1685GC, the Providers are appealing the exclusion of dual eligibles where Part A did not make a payment **only** from the ***SSI/Medicare fraction (i.e.,*** "It is the Providers' contention that these days must [be] excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.")[5] Conversely, in Case No. 23-0219GC, the *Statement of Issue, Facts and Statement of the Legal Basis*, clearly identify the Providers' challenge over ***both the exclusion of days from the Medicare fraction and the inclusion in the numerator of the Medicaid fraction***. Moreover, there is an additional *Facts* section, which references the impact of the August 11, 2004 Final Rule, which is not even mentioned in the Group Issue Statement in Case No. 21-1685GC.

In its consolidation request, QRS suggests that Case No. 21-1685GC includes two components of the Dual Eligible Days issues and asserts that the Providers "will now only be pursuing the Improper Rule Making Component . . . " because of the "Empire" decision. However, the regulation at 42 C.F.R. § 405.1837 and Board Rules 12.2 and 13, both indicate "[t]he matter at issue in the group appeal must involve a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group."

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[2] *See Empire Health Found. v. Azar*, 958 F.3d 873, 886 (9th Cir. 2020)
[3] *See* Board Rules 4.6, 5.4, 7.1.1. *See also* 42 C.F.R. § 405.1837(b).
[4] Board Rules v. 2.0 (eff. 8/29/2018) Appendix B: Model Form B – Group Appeal Request.
[5] Group Issue Statement in Case 21-1685GC (Sept. 8, 2021).

As far as the issues in Case Nos. 21-1685GC and 23-0219GC being considered "duplicative," the Board disagrees with this contention. The mere fact that QRS filed two separate CIRP groups including the same calendar year (CY 2017), only substantiates the Board's position that QRS considered the issues to be different. Specifically, QRS elected to create a second group under Case No. 23-0219GC, rather than adding the two CY 2017 participants to the pending CYs 2016-2017 CIRP group under Case No. 21-1685GC which, to date, is still not designated to be fully formed.

The Board directs QRS' attention to Board Rule 4.6, which specifically prohibits "Duplicate Filings":

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

In summary, the Board finds that:

1. QRS' statement in its January 4, 2024 correspondence indicates that it will be pursuing only the Improper Rule Making Component (the only issue under appeal) in Case No. 21-1685GC;
2. The "Improper Rulemaking" aspect of the Dual Eligible days was NOT the original issue under appeal in Case No. 21-1685GC;
3. QRS has certified that Case No. 23-0219GC is fully formed (even though the "alleged duplicate group" under Case No. 21-1685GC was pending at that time and was not yet designated to be complete);
4. By certifying Case No. 23-0219GC to be complete, QRS confirmed that all eligible providers for CY 2017 were included in the group for the SSI & Medicaid Fraction Dual Eligible Days issue, ***without the inclusion of Deer Valley Medical Center (Prov. No. 03-0092)***.

Based on these considerations, the Board hereby dismisses Case No. 21-1685GC and removes it from the docket. The Board considers QRS' January 4, 2024 correspondence to be a "withdrawal" of Case No. 21-1685GC in that it has indicated it is no longer pursuing the single group issue for the two participants: John C. Lincoln Medical Center (Prov. No. 03-0014) for FY 2016 and Deer Valley Medical Center for FY 2017 (Prov. No. 03-0092).

Regarding the surviving CIRP group, Case No. 23-0219GC, the Board has recently determined that the SSI Fraction and Medicaid Fraction Dual Eligible Part A Days are distinct issues that must be separately appealed in that the exclusion of days associated with no-pay Part A situations, where the underlying patient is a dual eligible, does not automatically mean such days must be counted in the Medicaid fraction.[6] The Parties will receive further correspondence regarding the bifurcation under separate cover.

Board Members:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/9/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, FSS

[6] To that end, the Board has been reversing mergers of companion SSI fraction dual eligible days cases with Medicaid fraction dual eligible days cases that were consolidated on the Board's own motion in error.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Russell Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, #570A
Arcadia, CA 91006

Lorraine Frewert
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Alhambra Hospital Medical Center (Provider Number 05-0281)
FYE: 06/30/2018
Case Number: 22-1355

Dear Mr. Ravindran and Ms. Frewert,

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

Background:

A. *Procedural History for Case No. 22-1355*

On February 24, 2022, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On August 23, 2022, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment – Medicaid Eligible Days[1]
3. DSH/SSI (Systemic Errors)[2]
4. DSH Payment – Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction)[3]
5. DSH/SSI Unduly Narrow Definition of SSI Entitlement[4]
6. DSH Payment – Medicare/SSI and Medicaid Fractions – Medicare Managed Care Part C Days[5]

[1] This issue was withdrawn on April 10, 2023.
[2] On February 16, 2023, this issue was transferred to PRRB Case No. 23-0263GC.
[3] This issue was withdrawn on October 26, 2022.
[4] On February 16, 2023, this issue was transferred to PRRB Case No. 23-0263GC.
[5] On February 16, 2023, this issue was transferred to PRRB Case No. 23-0264GC.

7. DSH Payment – SSI/Medicare and Medicaid Fractions – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]

As the Provider is owned by AMHC Healthcare and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 3, 5, 6 and 7 to AMHC Healthcare groups on February 16, 2023. As a result, the remaining issue in this appeal is Issue 1.

On April 11, 2023, the Provider filed its preliminary position paper.

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

On August 9, 2023, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-0263GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[7]

As the Provider is commonly owned by AMHC Healthcare, the Provider transferred its Issue 3 – DSH/SSI Percentage (Systemic Errors) to the CIRP group under 23-0263GC, AMHC Healthcare CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, on February 16, 2023. The Group Issue Statement in Case No. 23-0263GC reads:

> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's

[6] On February 16, 2023, this issue was transferred to PRRB Case No. 23-0265GC.
[7] Issue Statement at 1 (Aug. 23, 2022).

seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.

CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this terms is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597

> S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[8]

The amount in controversy listed for both Issues 1 and 3 in the Provider's individual appeal request is $155,290.

On April 11, 2023, 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.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[9]

[8] Group Issue Statement, Case No. 23-0263GC.
[9] Provider's Preliminary Position Paper at 8-9 (Apr. 11, 2023).

MAC'S Contentions:

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[10]

Failing that, the MAC argues the realignment sub-issue is premature:

> In this case, the MAC did not, and cannot, make a determination over SSI realignment. The only party that can make the election regarding the fiscal year end for the SSI percentage is the Provider. Since there is no MAC determination for the Provider to contest, the Board does not have jurisdiction over this issue, pursuant to 42 C.F.R. § 405.1803 (Exhibit C-8).
>
> The Provider's appeal is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3), and as a result, the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.
>
> The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[11]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issues are considered the same issue by the Board.[12]

Finally, the MAC argues "the Provider did not file [a] **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[13] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts regarding the merits of its claim in its preliminary position paper."[14] In more detail:

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[10] Jurisdictional Challenge at 6-7 (Aug. 9, 2023).
[11] *Id*. at 7.
[12] *Id*. at 6.
[13] *Id*. at 8.
[14] *Id*. at 10.

> Within its Provider's preliminary paper, the Provider makes the broad allegation that "The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30)" yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[15]

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), 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 analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the 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. As set forth below, the Board dismisses both aspects of Issue 1.

[15] *Id*.
[16] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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. 23-0263GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[17] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH/SSI (Systemic Errors) issue in group Case No. 23-0263GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH SSI Percentage is improper due to a number of factors. Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue in Case No. 23-0263GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/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, the Provider is pursuing that issue as part of the group under Case No. 23-0263GC, 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's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 23-0263GC.

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[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] PRRB Rules v. 3.1 (Nov. 2021).
[21] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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. 23-0263GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[22]

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***

[22] (Emphasis added).

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.[23]

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."[24]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, based on the record before it, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 23-0263GC 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 Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

Conclusion:

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

[23] Last accessed April 9, 2024.
[24] Emphasis added.

As no issues remain pending, the Board hereby closes Case No. 22-1355 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/9/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 W Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Board Decision***
SRI Aurora FY 2009 Medicaid Eligible Medicare Unmatched Days CIRP Group
FYE: 12/31/2009
Case Number: 15-0216GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 15-0216GC pursuant to a Jurisdictional Challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's analysis and determination is set forth below.

Background

On October 21, 2014, the Board received a group appeal request from the Group Representative, Strategic Reimbursement Group. The Initial Appeal contained six (6) providers:

1). 52-0102 Aurora Lakeland Medical Center (Fiscal Year Ending ("FYE") 12/31/2009)
2). 52-0138 Aurora Health Care Metro (FYE 12/31/2009)
3). 52-0139 Aurora West Allis Memorial Hospital (FYE 12/31/2009)
4). 52-0189 Aurora Medical Center Kenosha (FYE 12/31/2009)
5). 52-0193 Aurora BayCare Medical Center (FYE 12/31/2009)
6). 52-0198 Aurora Medical Center Oshkosh (FYE 12/31/2009)

On May 6, 2015, the Board denied the transfer request for Aurora Sheboygan Memorial Hospital (52-0035, FYE 12/31/2009). On September 29, 2015, Aurora Health Care Metro (52-0138, FYE 12/31/2009) was transferred to the Group Appeal.

The Group was fully formed on May 17, 2023.

The Provider filed its Preliminary Position Paper on June 8, 2023, and the MAC filed its Preliminary Position Paper on September 26, 2023.

On October 31, 2023, the MAC filed a Jurisdictional Challenge, and the Provider has not filed a response to date. A hearing date of September 16, 2024 was scheduled for this appeal.

Medicare Contractor's Contentions

The MAC argues 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. The MAC contends that the Providers had "ample time to review and analyze the requested MedPAR data and outline specific issues with the data."[1] The MAC states "[t]o date, the Group has not identified any specific discrepancies or provided any documentation to support its assertion that the SSI percentages are flawed. The Group has failed to include any evidence to establish the material facts in this case relating to excluded Medicaid Eligible days."[2]

The MAC cites *to Helena Regional Medical Center*, (FYE 12/31/2014, Case No. 17-2247) and *Wilkes Regional Medical Center*, (FYE 09/30/09, Case No. 14-2674), both cases in which the Board dismissed the Medicaid Eligible Days issue because the Provider failed to submit a listing of the additional days. Here, the Providers have failed to include a list of additional Medicaid eligible days with its preliminary position paper or to submit such list under separate cover. The MAC requests that the Board consider this issue as abandoned and dismiss the appeal in its entirety.

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." To date, the Provider has not filed a response to the MAC's Jurisdictional Challenge. The Provider had until December 1, 2023, to file a timely response.

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.

According to its Appeal Request, the Providers assert that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Providers states the Issue as:

> The Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Providers Operating Disproportionate Share Hospital, Low

[1] MAC Jurisdictional Challenge at 1
[2] *Id*. at 5

> Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations").
>
> The Provider contends that these days have been incorrectly identified as Medicare days and that they are not included in the Medicare Fraction (or SSI ratio) of the DSH calculation as indicated by CMS. Provider requests that the necessary files be provided to review the Medicare Fraction and determine if the omitted days were or were not included in the Medicare Fraction. The Provider requests any days omitted from their Calculations on the premise that these days were in fact included in the Medicare Fraction, but as a result of review were identified to have not been included in the Medicare Fraction, be instead properly included in the hospital's Calculations in order to correct the Calculations to be consistent with statute 42 U.S.C. 1395ww(d)(5)(F)(vi)(II).[3]

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

The Providers' preliminary position paper indicated that it would be sending the eligibility listing under separate cover.

Board Rule 7.2 (B) 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 Providers 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 (B).

Notably, the Providers have not included a list of additional Medicaid eligible days with their preliminary position paper or submitted such listings under separate cover. The Providers have essentially abandoned the issue by failing to properly develop their arguments and to provide supporting documents or to explain why they cannot produce those documents, as required by the regulations and the Board Rules.[4]

---

[3] Providers' Appeal Request (October 21, 2014).

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

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

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

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) 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,[5] Board Rule 25.2 (A) requires that "the parties must exchange all available documentation as exhibits to fully support your position." This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2 (B) 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, 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 opposing party.

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

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

> 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" 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 Providers have 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 have the Providers provided any explanation as to why the documentation was absent or what is being done to obtain it, consistent with Board Rule 25.2 (B). Indeed, without any days identified in the position paper filing, the Board assumes that there are no days and $0 actually in dispute for this issue.

The Board finds that the Providers have failed to comply with the Board's procedures with regard to filing their position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2 (A) and 25.2 (B) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or to describe why said evidence is unavailable.[6]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

---

[6] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

Decision

The Board hereby dismisses the issue in its entirety as the Provider failed to meet the Board requirements for position papers for this issue, in compliance with 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 15-0216GC 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/10/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
College Station Medical Center (Provider Number 45-0299)
FYE: 09/30/2017
Case Number: 22-0671

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0671, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 22-0671

On February 7, 2022, College Station Medical Center ("College Station" or "Provider"), appealed a Notice of Program Reimbursement (NPR) dated August 16, 2021, for its fiscal year end (FYE) September 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[2]
- Issue 3: DSH Medicaid Eligible Days
- Issue 4: DSH Medicare Part C Days- Post 10/01/2013[3]
- Issue 5: DSH Dual Eligible Days[4]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to Community Health groups on September 8, 2022. The

[1] Provider's Request for Hearing at Issue Statement (Feb. 7, 2022).
[2] The Provider transferred this issue to Case No. 20-0997GC on September 8, 2022.
[3] The Provider transferred this issue to Case No. 19-2620GC on September 8, 2022.
[4] The Provider transferred this issue to Case No. 20-1383GC on September 8, 2022.

remaining issues in this appeal are Issue 1, DSH SSI Percentage (Provider Specific), and Issue 3, DSH – Medicaid Eligible Days.[5]

On September 21, 2022, the Provider filed its Preliminary Position Paper.

On January 10, 2023, the Medicare Contractor filed its Preliminary Position Paper.

On January 12, 2023, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1, the DSH SSI Percentage (Provider Specific) issue and Issue 3, the DSH Medicaid Eligible Days issue. The Provider Representative filed a response on February 13, 2023.

B. Description of Issue 1 in the Appeal Request and Group Appeal

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

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

On September 21, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[5] MAC's Jurisdictional Challenge, at 2 (Jan. 12, 2023).
[6] Provider's Request for Hearing, Issue Statement (Feb. 7, 2022).

Calculation of the SSI Percentage

Provider Specific

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

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

The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. S*ee* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[7]

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 $20,356. $20,356 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 contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 20-0997GC, *CHS CY 2017 DSH SSI Percentage Group*. The Portion of Issue 1 concerning realignment should be

[7] Provider's Preliminary Position Paper, at 8-9 (Sept. 21, 2022).

dismissed because "[t]here was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies."[8]

The MAC continues, noting that "[l]astly, 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."[9]

Issue 3 – DSH Medicaid Eligible Days

The MAC also argues that "[t]he Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, all exhibits, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853."[10] The MAC argues that the Provider did not do these things, with respect to the Medicaid eligible days issue.

Provider's Response:

The Provider argues CMS does not make certain SSI data available and there is "no process through which the provider could obtain this necessary information"[11] to support all patient payment status codes.

The Provider contends that the final deadline for submitting a listing for the additional eligible days would be the Final Position Paper, citing to Board Rule 27.1. Lastly, the Provider maintains it was adversely affected by COVID-19 and continues to face operational challenges.[12]

Board Analysis and Decision:

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

A. SSI Provider Specific

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

[8] MAC's Jurisdictional Challenge, at 2.
[9] *Id.*
[10] *Id.*
[11] Provider's Jurisdictional Response at 1 (Feb. 13, 2023).
[12] *Id.* at 2.

1. First Aspect of Issue 1

The Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers.

In making this finding, the Board first 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 the Provider has failed to explain how this argument is ***specific to this provider***, as the issue title asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors are specific to this provider.

To this end, the Board has also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> 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 data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [14]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[15]

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

[14] (Last accessed April. 9, 2024.)
[15] (Emphasis added.)

appealing from a September 30 fiscal year end, therefore a request for realignment is illogical, as the Provider's cost reporting period is congruent with the Federal fiscal year.

B. DSH Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees [*sic*] with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[16]

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 which it desires to be included in its Medicaid percentage and DSH computations, with its appeal request.

On September 21, 2022, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (e.g., whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

[16] Provider's Request for Hearing, Issue Statement (Feb. 7, 2022).
[17] Provider's Preliminary Position Paper, at 10 (Sept. 21, 2022)

Calculation of Medicaid Eligible Days

Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

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

The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.

Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2017 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

While the Calculation Support filed with their appeal notes a net "estimated impact" of $51,798, 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 *sent*

under separate cover.[18] However, that listing has not been forthcoming and has not ever been made part of the record in this appeal 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, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[19]

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

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

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

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

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

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

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[23]

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

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

> data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. 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 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 to describe why said evidence is unavailable.[25] The Board takes administrative notice that it has made similar dismissals in other cases in which QRS was the designated representative and, notwithstanding, QRS again failed to provide the Medicaid eligible days listing with its preliminary position paper.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as 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 in violation of the Board Rules and regulations. As

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

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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/10/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

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

RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
MultiCare Deaconess Hospital (Provider Number 50-0044)
FYE: 09/30/2016
Case Number: 20-0505

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. 20-0505*

On June 27, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On December 3, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Community Health groups on June 18, 2020. After the withdrawal of Issue 4, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 18, 2020, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on July 27, 2020.
[3] On June 18, 2020, this issue was transferred to PRRB Case No. 19-1410GC.

On **December 13, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

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

On **July 27, 2020**, the Provider timely filed its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days were at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days."[5] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $85,329 calculated using an *estimated* 150 days.

On **August 13, 2020**, the MAC filed a request with the Provider to supply the DSH Medicaid Days listing and support.

On **September 25, 2020**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issue 1 requesting that the Board dismiss the issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **November 19, 2020**, the Medicare Contractor filed its preliminary position paper. With regard to Issue 3, the Medicare Contractor's position paper noted that: (1) the Provider had

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[4] (Emphasis added.)
[5] Provider's Preliminary Position Paper at 8 (July 27, 2020).
[6] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

failed to include a Medicaid eligible days listing with its position paper, notwithstanding its obligation under Board Rules to file a fully developed position paper with all available documentation necessary to support its position; and (2) the Provider had failed to respond to any of the Medicare Contractor's requests for that Medicaid eligible days listing.

On **January 6, 2023**, the Medicare Contractor filed its Final Request for DSH Package in connection with Issue 3. In this filing, the Medicare Contractor noted that the preliminary paper stated the listing would be sent under separate cover but it was not and on August 13, 2020 it was requested. As no response was received, the Medicare Contractor formally filed a Final Request for DSH Package to formally request that a listing of the Medicaid eligible days at issue, plus supporting documentation, be provided to the Medicare Contractor within 30 days. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received from the Provider, on **July 24, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3.[7] Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion.

On **July 25, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 2, 2023**, over 2 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[8] The Listing was 2 pages with roughly 457 Medicaid eligible days. QRS' filing did not explain why the listing which was triple the original amount was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation

[7] Medicare Contractor's Motion to Dismiss at 4-5 (July 24, 2023).
[8] (Emphasis added.)

> . . .
>
> 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]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 19-1409GC, CHS CY 2016 DSH SSI Percentage CIRP Group, on June 18, 2020. The Group Issue Statement in Case No. 19-1409GC reads, in part:

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

[9] Issue Statement at 1 (Dec. 3, 2019).

6. Failure to adhere to required notice and comment rulemaking procedures.[10]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $87,000.

On July 27, 2020, 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 Washington and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Washington and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its 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]

C. Requests for Medicaid Eligible Days Listing and Support

The Medicare Contractor requested a listing of the 150 additional Medicaid Eligible Days being protested by the Provider in order to "potentially resolve this issue."[12] The Medicare Contractor sent a letter to the Provider (and to the Board) on August 13, 2020, requesting this listing and

[10] Group Issue Statement, Case No. 19-1409GC.
[11] Provider's Preliminary Position Paper at 8-9 (July 27, 2020).
[12] Medicare Contractor's Preliminary Position Paper at 20 (Nov. 19, 2020).

other documentation in an effort to resolve the issue before the Board.[13] This request was repeated in the contents of the Medicare Contractor's Preliminary Position Paper, submitted to the Provider and the Board on November 19, 2020.[14] On January 6, 2023, the Medicare Contractor submitted a third request for this documentation.[15]

MAC's Contentions

Issue 1 – DSH Payment/ 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 SSI realignment portion of the issue 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.[16]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[17]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or

[13] Medicaid Eligible Day Request Letter (Aug. 13, 2020).
[14] Medicare Contractor's Preliminary Position Paper at 20. *See also* Ex. C-6.
[15] Final Request for DSH Medicaid Eligible Days Support (Jan. 6, 2023).
[16] Jurisdictional Challenge at 8 (Sept. 25, 2020).
[17] *Id*. at 5-7.

describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[18]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

Provider's Response

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

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[19] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (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."

Issue 3 – DSH Payment – Medicaid Eligible Days

Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party." No such response was filed by the Provider and the time for doing so has elapsed.

On November 2, 2023, the Provider filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission". The letter contained no explanation as to why this was submitted almost 3.5 years after the filing of the Preliminary Position Paper, nor any additional information other than a redacted listing.

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

[18] Motion to Dismiss at 4-5 (July 24, 2023).
[19] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/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. 19-1409GC.

The DSH Payment/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."[20] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[21] 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."[22]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[23], the Board dismisses this aspect of the DSH Payment/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

[20] Issue Statement at 1.
[21] *Id.*
[22] *Id.*
[23] PRRB Rules v. 2.0 (Aug. 2018).

and, to that end, the Provider is pursuing that issue as part of the group under Case 19-1409GC, 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.[24] The Provider's reliance upon in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

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

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:

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

[25] (Emphasis added).

> [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]

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 the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[28] 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 Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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[26] Last accessed April 9, 2024.
[27] Emphasis added.
[28] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal in either the initial appeal or the position papers. The Provider also failed to respond to the Medicare Contractor's multiple requests for such a listing.

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees 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.[29]

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[30]

[29] Individual Appeal Request, Issue 3.
[30] Provider's Preliminary Position Paper at 8.

Board Rule 7.3.2 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.

In this case, 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, after multiple documented requests by the Medicare Contractor. 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.[31]

42 C.F.R. § 405.1853(b) 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*.[32]

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

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[31] *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.

[32] (Emphasis added).

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

> **Rule 25 Preliminary Position Papers**[33]
>
> **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 The 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**
>
> **25.2.1 General**
>
> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

[33] (Underline emphasis added to these excerpts and all other emphasis in original.)

> Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a *complete* preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on December 13, 2019 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[34]

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

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

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

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

> • if it has 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 or filing deadlines (*see* 42 C.F.R. § 405.1868),
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

On July 27, 2020, the Provider filed its preliminary position paper in which it indicated that its eligibility listing was imminent by promising that the listing was being sent under separate cover.[35] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request, listing the combined amount filed in the original appeal for the two remaining open issues.

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and 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 Medicare Contractor sent two (2) separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first notice was sent to the Provider on August 13, 2020 and the final request was sent to the Provider on January 6, 2023, *seven years after the end of the*

[34] (Emphasis added.)
[35] Provider's Preliminary Position Paper at 8 (July 7, 2020).

Provider's cost reporting period. The Provider failed to file any response to the 3rd and final request.

Due to the non-responsiveness of the Provider, on **July 24, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days because: (1) the Provider failed to timely furnish documentation (e.g., a listing of days with supporting documentation of Medicaid eligibility) in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); and (2) the Provider failed to furnish the list of additional Medicaid eligible days with its preliminary position paper in violation of Board Rules 25.2.1 and 25.2.2 (or when requested by the Medicare Contractor three separate times after that). The Medicare Contractor 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 failed to produce those documents, as required by the regulations and the Board Rules.[36]

Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion for Dismiss. However, the Provider ***failed*** timely respond to that Motion by the August 24, 2023 filing deadline (*i.e.*, 30 days after July 24, 2023).

However, on November 2, 2023 (2+ months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 2 pages with roughly 457 Medicaid eligible days. QRS' filing did not explain why the listing of triple the originally filed days was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***. Regardless, this filing was more than 2 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was almost 4 years past the deadline for including it with its preliminary position paper*** since the position paper deadline was July 27, 2020.

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)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[37] 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***.

The fact that the Listing was filed 4 months after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with

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

its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 2, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 3½ years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing, consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 3 and the alleged "Supplement" was filed ***more than 2 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 3.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 450 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to identify a single day at issue until almost 4 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the December 12, 2019 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable, consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits, consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[38]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[39] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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[38] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."
[39] (Emphasis added.)

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[40]

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC 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 Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 20-0505 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/11/2024

X Kevin D. Smith, CPA

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

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

[40] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

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

RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days***
Memorial Hospital of Salem County (Provider Number 31-0091)
FYE: 12/31/2017
Case Number: 22-0432

Dear Messrs. Summar 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. 22-0432*

On August 9, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On January 14, 2022, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "CHS") 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, 4, and 5 to CHS groups on August 15-16, 2022. The remaining issues in this appeal are Issues 1 and 3.

On September 7, 2022, the Provider submitted its preliminary position paper.

[1] On August 15, 2022, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On August 15, 2022, this issue was transferred to PRRB Case No. 19-2620GC.
[3] On August 16, 2022, this issue was transferred to PRRB Case No. 20-1383GC.

On October 13, 2022, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

On November 28, 2022, the Medicare Contractor filed its preliminary position paper.

On January 12, 2023, the Medicare Contractor filed a Request for Days Documentation, stating that the Provider has not included a list of the Medicaid days in question nor any supporting documentation.

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 Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation
>
> . . .
>
> The Provider 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]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, on August 15, 2022. The Group Issue Statement in Case No. 20-0997GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[4] Issue Statement at 1 (January 14, 2022).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $25,235.

On September 7, 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' 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

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

> analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

Issue 1 – DSH Payment/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 SSI realignment portion of the issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[7]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[8]

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[6] Provider's Preliminary Position Paper at 8-9 (September 7, 2022).
[7] Jurisdictional Challenge at 7 (October 13, 2022).
[8] *Id*. at 4-6.

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing that the Provider:

> . . .failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper.
>
> ***
>
> . . .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.
>
> ***
>
> . . .makes the broad allegation '…the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days…'
>
> ***
>
> . . .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 Medicare Contractor requests that the Board dismiss Issue 3.

2. <u>Provider's Jurisdictional Response</u>

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (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." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different

[9] *Id* at 11-12 (October 13, 2022).
[10] Board Rule 44.4.3, v. 3.1 (Nov. 2021)

deadline, an opposing party may send a response, with relevant supporting documentation, within 30 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 (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 Payment/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 Errors) issue that was appealed in PRRB Case No. 20-0997GC.

The DSH Payment/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."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] 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."[13]

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 Payment/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

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*

duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/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, the Provider 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.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

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

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* 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.[16]

[14] PRRB Rules v. 3.1 (Nov. 2021).
[15] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[16] (Emphasis added).

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh [17]

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."[18]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, *based on the record before it*, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue.[19] 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 Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

[17] Last accessed April 10, 2024.
[18] Emphasis added.
[19] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a CHS CIRP group, per 42 C.F.R. § 405.1837(b)(1).

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

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees [] 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.[20]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[21]

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[20] Individual Appeal Request, Issue 3.
[21] Provider's Preliminary Position Paper at 8.

Board Rule 7.3.1.2 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.

In this case, 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.[22]

42 C.F.R. § 405.1853(b) 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) states:

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[22] *See also* Board's 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).

> 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.

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,* 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.[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)(4)(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,

---

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

> • upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868),
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

The Board 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)(4)(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. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days and that the actual amount in dispute is $0 for this issue. Indeed, based on these facts plus the Provider's failure to respond to either the Medicare Contractor's request for the listing or the Medicare Contractor's Motion to Dismiss on this issue, the Board assumes that the Provider has abandoned this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(4)(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 to describe why said evidence is unavailable. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[28] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or to file a copy following the MAC's Motion to Dismiss.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (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 Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue, in compliance with 42

[27] (Emphasis added).
[28] An example of a CHS individual provider case which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days includes Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 22-0432 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/11/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Cecile Huggins
Palmetto GBA
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

RE: ***Board Decision*** **– SSI Percentage (Provider Specific)**
Johnson City Medical Center (Provider Number 44-0063)
FYE: 06/30/2018
Case Number: 23-0173

Dear Mr. Ravindran and Ms. Huggins,

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

Background:

A. ***Procedural History for Case No. 23-0173***

On May 31, 2022, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2018.

On November 7, 2022, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Medicaid Eligible Days[1]

The remaining issue in this appeal is Issue 1.

On July 3, 2023, the Provider filed its preliminary position paper.

On September 14, 2023, the Medicare Contractor filed its preliminary position paper.

On October 16, 2023, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

[1] This issue was withdrawn on August 23, 2023.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-0174GC

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.[2]

As the Provider is commonly owned by Ballad Health, the Provider was directly added to the Ballad Health CIRP group under 23-0174GC, Ballad Health CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, on November 7, 2022. The Group Issue Statement in Case No. 23-0174GC reads:

> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.
>
> CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

[2] Issue Statement at 1 (Nov. 7, 2022).

> CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J., concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this terms is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").
>
> In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or a change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.
>
> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[3]

The amount in controversy listed for both Issues 1 in the instant appeal and as a participant in PRRB Case No. 23-0174GC is $466,448.

On July 3, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[3] Group Issue Statement, Case No. 23-0174GC

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[4]

MAC'S Contentions:

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper. PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > If the provider fails to brief an appealed issue in its position paper, the Board will consider an unbriefed issue abandoned and effectively withdrawn.[5]

Failing that, the MAC argues the realignment sub-issue is premature:

[4] Provider's Preliminary Position Paper at 7-8 (Jul. 3, 2023).
[5] Jurisdictional Challenge at 6 (Oct. 16, 2023).

> 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.[6]

In addition, the MAC argues the portions of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment is duplicative of the appeal in Case No. 23-0174GC.[7]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[8] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper."[9] In more detail:

> Within the Provider's Preliminary Position Paper, the Provider makes the broad allegation that '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,' yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[10]

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[6] *Id*. at 6-7.
[7] *Id*. at 4-6.
[8] *Id*. at 7.
[9] *Id*. at 9.
[10] *Id*.

Provider's Response:

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), 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 analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the 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. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the SSI accuracy issue that was appealed in PRRB Case No. 23-0174GC.

The DSH Payment/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."[12] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] 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."[14]

[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

The Provider's SSI accuracy issue in group Case No. 23-0174GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH SSI Percentage is improper due to a number of factors. Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the SSI accuracy issue in Case No. 23-0174GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board dismisses this aspect of the DSH Payment/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, the Provider is pursuing that issue as part of the group under Case No. 23-0174GC, 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.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 23-0174GC.

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. 23-0174GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

[15] PRRB Rules v. 3.1 (Nov. 2021).
[16] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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.[17]

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [18]

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."[19]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

[17] (Emphasis added).
[18] Last accessed April 10, 2024.
[19] Emphasis added.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 23-0174GC are the same issue.[20] 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 Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The Board finds the second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue was abandoned by the Provider. Board Rule 25.3 reads, in pertinent part:

> If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

The Board finds that the realignment portion of the DSH Payment/SSI Percentage issue was not briefed in the preliminary position paper and is therefore, abandoned.

The Board also notes that the realignment portion of the appealed issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—would have been dismissed by the Board even if it was briefed, as the issue is premature.

The Board notes 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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board notes that it lacks jurisdiction in this aspect of the appeal.

Conclusion:

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 23-0174GC and the SSI realignment issue was abandoned by the Provider by failing to brief the issue in the Preliminary Position Paper. As no issues remain pending, the Board hereby closes Case No. 23-0173 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.

[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Ballad Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/11/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision***
Memorial Hospital of Salem County (Provider Number 31-0091)
FYE: 12/31/2016
Case Number: 21-0298

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Contractor's Jurisdictional Challenge and the Motion to Dismiss. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 21-0298

On April 27, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On October 19, 2020, the Board received the Provider's individual appeal request. The initial individual appeal request contained four (4) issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage[1]
- Issue 3: DSH- Medicaid Eligible Days
- Issue 4: 2 Midnight Census IPPS Payment Reduction[2]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a Community Health group on May 20, 2021. The remaining issues in this appeal are Issues 1 and 3.

On **November 30, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This

[1] On May 20, 2021, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on August 18, 2023.

Notice also gave the following instructions to the Provider regarding the content of its 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.[3]

On **June 11, 2021**, the Provider submitted its preliminary position paper. With respect to Issue 3, the Provider suggested that a list of Medicaid eligible days at issue was imminent by promising that one was being sent under separate cover. However, no such filing was made by the Provider and no explanation was included explaining why that listing was not included with the position paper filing. Indeed, the filing failed to even provide *the material fact* of how many Medicaid eligible days are at issue and instead asserted that "[b]ased on the Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its' 2016 cost report does not reflect an accurate number of Medicaid eligible days."[4] As a result, the Provider included, as an Exhibit, the original "estimated impact" for this issue of $46,924 based on an *estimated* 50 days.

On **September 17, 2021**, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

On **September 28, 2021**, the Medicare Contractor filed its preliminary position paper.

On **January 5, 2023**, the MAC filed a "3rd and Final request" with the Provider to supply the DSH Medicaid Days listing and support. In this filing, the Medicare Contractor noted that it had previously reached out February 3, 2021 and April 23, 2021 to obtain the listing, but had not received any form of response. The preliminary paper also stated the listing would be sent under separate cover, but it was not. As no response was received, the Medicare Contractor formally filed this "Final Request" for a DSH Package to formally request that a listing of the Medicaid eligible days at issue, plus supporting documentation, be provided to the Medicare Contractor. Notwithstanding the formal request, the Provider failed to file any response to the Medicare Contractor.

As no response was received by the Provider, on **August 17, 2023**, the Medicare Contractor filed a Motion to Dismiss Issue 3- DSH Medicaid Eligible Days because: (1) the Provider failed to furnish documentation in support of its claim for additional Medicaid eligible days (or explain why such documentation is unavailable); (2) the Provider failed to furnish the Medicaid eligible days listing with its preliminary position paper, in violation of Board Rules 25.2.1 and 25.2.2; and (3) the Provider has effectively abandoned Issue 3.[5] Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion to Dismiss. However, the Provider ***failed*** timely respond to that Motion.

---

[3] (Emphasis added.)
[4] Provider's Preliminary Position Paper at 8 (June 11, 2021).
[5] Medicare Contractor's Motion to Dismiss at 5 (August 17, 2023).

On **November 13, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **November 14, 2023**, 2 months after the deadline for responding to the Motion to Dismiss Issue 3, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the *caveat* that the "Listing [is] *pending finalization* upon receipt of State eligibility data."[6] The Listing was 2 pages with roughly 375 Medicaid eligible days. QRS' filing did not explain why the listing which was seven times (7x) the original amount or was being submitted at this late date or why it was not final (*i.e*., why it was "pending finalization") at this late date, ***more than 7 years after the fiscal year at issue had closed***.

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

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[7]

On June 11, 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**

[6] (Emphasis added.)
[7] Provider's Request for Hearing, Issue Statement (October 19, 2020)

> 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 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 L*oma 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/HCFA/OIS, 09-07-009, which was published 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).

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On September 17, 2021, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of an issue which was transferred into Group Case No. 19-1409GC, *"CHS CY 2016 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 appeal is premature, as the Provider has not exhausted all available remedies."[8]

Issue 3 – DSH Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.

[8] MAC's Jurisdictional Challenge, at 2. .

b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of PRRB Rules 7, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[9]

Provider's Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (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." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 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 (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 Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/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

[9] Motion to Dismiss at 5 (August 17, 2023).
[10] Board Rule 44.4.3, v. 3.1 (Nov. 2021)

Percentage (Systemic Errors) issue transferred into Group Case No. 19-1409GC, *CHS CY 2016 DSH SSI Percentage CIRP Group*.

The DSH Payment/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."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] 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."[13]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[14], the Board dismisses this aspect of the DSH Payment/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, the Provider is pursuing that issue as part of the group under Case 19-1409GC which it is required to do since it is a common issue subject to the mandatory CIRP rules 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.[15] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC in its appeal request and further, the Provider failed to respond to the Jurisdictional Challenge.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic Baystate data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position

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[11] Issue Statement at 1.
[12] *Id*.
[13] *Id*.
[14] PRRB Rules v. 2.0 (Aug. 2018).
[15] 5 The types of systemic errors documented in the Baystate did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also Baystate Med. Ctr. v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).

papers "to be fully developed and include all available documentation necessary to provide a thorough understanding of the parties' positions." For example, the Provider claims that SSI entitlement can be ascertained from State records but fails to explain how or establish what those alleged records show, or identify any days in dispute based on those records (much less explain how the State record issue would be provider specific and not subject to the CIRP group rules and not already part of the CIRP group to which it transferred the systemic 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 Federal fiscal years that encompass the hospital's cost reporting period. Under this provision, the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers can obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [16]

This CMS webpage describes access to DSH data from 1998 to 2017 as follows: "DSH is now a self-service application. This new self-service process enables you to enter your data request(s) and retrieve your data files through the CMS Portal."

Accordingly, *based on the record before it*, the Board finds that the remaining issue #1 in the instant appeal and the group issue from Group Case 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding 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 filed on October 19, 2020, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. 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

[16] Last accessed February 24, 2023.

> percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[17]

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

As discussed above, the Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.

Board Rule 7.2 (B) 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 (B).

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.[18]

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

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

[17] Provider's Appeal Request (October 19, 2020).
[18] See also Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (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.

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

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

> **Rule 25 Preliminary Position Papers**[19]
>
> **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 The 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.

[19] (Underline emphasis added to these excerpts and all other emphasis in original.)

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on November 30, 2020 included instructions on the content of the Provider's preliminary position paper consistent with the above Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 3, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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.[20]

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

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

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

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

> • if it has 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 or filing deadlines (*see* 42 C.F.R. § 405.1868),
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

On June 11, 2021, the Provider filed its preliminary position paper in which it indicated that it the eligibility listing was imminent by promising that the listing was being sent under separate cover.[21] Significantly, the position paper did ***not*** include *the material fact* of how many Medicaid eligible days remained in dispute in this case, but rather continued to reference the "estimated impact" included with its appeal request (i.e., the *estimated* impact of $46,924 based on an *estimated* 50 days).

In its Motion to Dismiss, the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and 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 Medicare Contractor states it sent multiple separate requests for the Provider's list of Medicaid Eligible days (and also discussed the lack of the listing in the Medicare Contractor's own position paper filing). The first requests were sent in 2021 and the final request was sent to the Provider

[20] (Emphasis added.)
[21] Provider's Preliminary Position Paper at 8 (June 11, 2021).

on January 5, 2023, *seven years after the end of the Provider's cost reporting period*. The Provider failed to file any response to the 3rd and final request.

Due to the non-responsiveness of the Provider, on **August 17, 2023**, the Medicare Contractor filed a Motion to Dismiss, requesting dismissal of DSH Medicaid Eligible Days issue, asserting that the Provider had essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it failed to produce those documents, as required by the regulations and the Board Rules. Pursuant to Board Rule 44.3, the Provider had 30 days to respond to the Motion to Dismiss. However, the Provider ***failed*** to timely respond to that Motion by the September 17, 2023 filing deadline (*i.e.*, 30 days after August 17, 2023).

However, on November 14, 2023 (2 months after the deadline to respond to the Motion), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" and added the caveat that the "Listing [is] pending finalization upon receipt of State eligibility data." The Listing was 2 pages with roughly 375 Medicaid eligible days. QRS' filing did not explain why the listing was more than 7x the days originally reported or why it was being submitted at this late date or why it was not final (*i.e.*, why it was "pending finalization"), ***more than 7 years after the fiscal year at issue had closed***. Regardless, this filing was 2 months past the deadline for responding to the Motion to Dismiss *and, more importantly,* ***was almost 2 years past the deadline for including it with its preliminary position paper,*** since the position paper deadline was June of 2021.

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)(4)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[22] 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***.

The fact that the Listing was filed one day after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include the information with its preliminary position paper or its failure to timely respond to the Motion to Dismiss. Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the November 14, 2023 filing as a "Supplement to Position Paper" and does not accept that filing because:

1. The alleged "Supplement" was filed ***more than 2 years*** *after the deadline* for that exhibit to be included with its preliminary position paper filing, consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)). Indeed, the Provider failed to timely reply to the Medicare Contractor's Motion to Dismiss Issue 3 and the alleged "Supplement" was filed ***2 months*** *after the deadline* for filing a response to the Motion to Dismiss Issue 3.

2. The alleged "Supplement" fails to explain the following critical information: (a) *why* it was being filed so late (*i.e.*, upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the roughly 375 days was not previously available, *in whole or in part* (*i.e.*, it is not

[22] (Emphasis added).

clear why the Provider failed to identify a single day at issue until almost 3 years after this appeal was filed and more than 7 years after the fiscal year at issue had closed); and (c) why the listing still was ***not*** a "*final*" listing at this late date.

3. Neither the Board Rules nor the November 30, 2020 Case Acknowledgment and Critical Due Dates permit the Provider to file a "Supplement" to its preliminary position paper (nor did the Provider allege in the "Supplement" filing that they do).

4. Given the fact that the *material* facts (*e.g.*, the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable, consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits, consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the position paper since no specific days or listing were included with the preliminary position paper.[23]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less to provide the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board must find that there are no such days in dispute and that the actual amount in controversy is $0.

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

****

[23] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[24] (Emphasis added.)

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

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal because it is duplicative of the issue in PRRB Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and further, the Provider failed to properly develop the issue to establish it as a separate and distinct 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 in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-0928 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/17/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Michael Redmond
Novitas Solutions, Inc.
2020 Technology Pakwy., Ste. 100
Mechanicsburg, PA 17050

RE: ***Board Decision* – Medicaid Eligible Days Issue**
Houston Methodist Hospital (Prov No. 45-0358)
FYE 12/31/2014
Case No. 19-2505

Dear Mr. Ravindran and Mr. Redmond,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above-referenced appeal involving Houston Methodist Hospital ("Provider"). The Provider's current designated representative is James Ravindran of Quality Reimbursement Services, Inc. ("QRS"). The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 19-2505*

On **February 28, 2019**, the Medicare Contractor issued the Provider a Notice of Program Reimbursement ("NPR") for the Provider's fiscal year ending December 31, 2014 ("FY 2014").

On **August 27, 2019**, the Provider filed an individual appeal request with the Board appealing the FY 2014 NPR. The initial Individual Appeal Request contained nine (9) issues:

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

[1] This issue was dismissed by the Board on November 17, 2021.
[2] On January 31, 2020, this issue was transferred to PRRB Case No. 19-0205GC.
[3] On January 31, 2020, this issue was transferred to PRRB Case No. 19-0209GC.
[4] On January 31, 2020, this issue was transferred to PRRB Case No. 19-0195GC.
[5] On January 31, 2020, this issue was transferred to PRRB Case No. 19-0206GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. Whether the LIP amount was calculated correctly.[7]
9. Standardized Payment Amount[8]

Significantly, for Issue 1, the appeal request stated that the Provider "is seeking reimbursement for an additional 310 Medicaid Eligible Days" and that "Of the additional 310 days, ***all days*** *relate to the eligibility identified* ***subsequent to cost report being filed but before cost report was finally settled***."[9]

As the Provider is commonly owned/controlled by Houston Methodist Hospital System ("Houston Methodist"), the Provider is subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason on **January 31, 2020**, the Provider transferred Issues 3, 4, 5, 6, 7 and 9 to Houston Methodist CIRP groups. Following the Board's dismissal of Issues 2 and 8, there is *only* one remaining issue in the appeal: Issue 1 (DSH Payment – Medicaid Eligible Days).

On **August 29, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> 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.[10]

On **April 23, 2020**, the Provider timely filed its preliminary position paper. Significantly, even though the Provider acknowledges in both the preliminary position paper and the appeal request (*see supra* discussion) that all of the 310 days were "identified subsequent to cost report being filed but before cost report was finally settled," the position paper did not identify the specific 310 Medicaid eligible days at issue as it did not include a listing of those days. Rather, with respect to Issue 1, the Provider argued:

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[6] On January 31, 2020, this issue was transferred to PRRB Case No. 19-0235GC.
[7] This issue was dismissed by the Board on November 17, 2021.
[8] On January 31, 2020, this issue was transferred to PRRB Case No. 19-2200GC.
[9] (Emphasis added.)
[10] (Emphasis added.)

> Medicaid Eligible Days results change over time. For this reason, providers *generally* ***prefer*** to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but *at this time* ***the Provider is seeking an additional 310 Medicaid Eligible Days*** in its cost report.[11]

As a result, the Provider included, an "estimated impact" for this issue of $36,149 based on their "at this time" estimate of 310 additional Medicaid Eligible Days.

On **July 15, 2020**, the Medicare Contractor timely filed its preliminary position paper. With respect to Issue 1, the Medicare Contractor states that "[t]o resolve this issue, the Provider must supply all required documentation stated per 42 C.F.R. § 413.24(2)(c) [*sic* § 413.24(c)]" which states: "*Adequacy of information: 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*."[12]

On **August 10, 2023**, the Board issued the Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each 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 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.[13]

On **January 17, 2024**, the Provider timely filed its final position paper.[14] Significantly, the final position paper does not discuss or brief the § 1115 waiver days issue. It is only by looking at Exhibit P-1 attached to the final position paper that it becomes clear that the 9,756 days cited in the final position paper pertain only to § 1115 waiver days. This is because Exhibit P-1 is entitled " Detail Listing of Medicaid Eligible **1115 Waiver Days** Log."[15] Moreover, the filing failed failed to fully identify 9,756 days at issue because the so-called "Detail Listing" included at Exhibit P-1 only included the following non-auditable data: (1) the "claim type" (all "Uninsured Charges"); (2) the "Source" (all "DY3 (UC Audit)"); (3) the "Discharge Date" and

[11] Provider's Preliminary Position Paper at 3 (Apr. 23, 2020) (emphasis added).
[12] Medicare Contractor's Preliminary Position Paper at 7 (Jul. 15, 2020).
[13] (Emphasis added).
[14] Provider's Final Position Paper at 1 (Jan. 17, 2024) (emphasis added).
[15] (Emphasis added.)

"Discharge Date"; and (4) the "Updated Routine Days of Care." With respect to Issue 5, the Provider argued:

> Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking an additional 9,765 Medicaid Eligible Days in its cost report.[16]

As a result, the Provider included, an "estimated impact" for this issue of $1,200,803 based on their "at this time" estimate of 9,756 additional § 1115 waiver days.

On **February 9, 2024**, the Medicare Contractor timely filed its final position paper. In it, they argue:

> The MAC contends that the Provider has abandoned the original Medicaid eligible days issue. The Provider has never submitted to the MAC a list of the original Medicaid eligible days for this issue. The MAC contends that the Provider has failed to previously file a complete preliminary position paper in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25. The MAC contends the Provider appears to be attempting to add an untimely issue of "Section 1115 Waiver Days" to this appeal within its Final position paper.[17]

Accordingly, the Medicare Contractor stated that it would be filing a jurisdictional challenge requesting that the Board dismiss the Medicaid eligible days issue.

On **February 20, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1 asserting that: (1) the Provider abandoned the original Medicaid eligible days issue because its preliminary position paper failed to address the substance of the issue and failed to include a listing of the specific 310 Medicaid eligible days at issue and; (2) the Provider is attempting to improperly and untimely add the § 1115 waiver days issue.

On **March 6, 2024**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS"). On **March 18, 2024**, QRS timely filed the Provider's response to the dismissal request asserting that the Provider had not abandoned the Medicaid eligible days issue, and that the Medicare Contractor jurisdictional challenge is not a proper filing to challenge the Provider's failure to brief the § 1115 waiver day issue in its preliminary position paper which it asserts ***in error*** was fully briefed in its final position paper (contrary to this assertion the § 1115 waiver day issue was ***not*** briefed in the final position paper).

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[16] *Id*. at 3.
[17] Medicare Contractor's Final Position Paper at 9 (Feb. 9, 2024).

Also on **March 18, 2024**, QRS filed a Supplement to Position Paper/Redacted Medicaid Eligible Days listing.[18] This listing was 40 pages and is entitled "Additional ME & 1115 Wiaver Days." It details 20,036 days based on the account number, patient name, admit date, discharge date and length of stay. QRS' filing did not explain why the listing of so many days was being submitted at this late date (***more than 9 years after the fiscal year at issue had closed***) or why there is another vastly different number of days listed from both the Preliminary Position Paper and Final Position Paper filings (*more than double* the 9,756 days cited in the final position paper ***and*** *more than 64 times larger* than the original 310 days cited in the original appeal request and the preliminary position paper).

B. Description of Issue 1 in the Appeal Request

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 describes Issue 5 as:

> **Statement of 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.
>
> HMH is seeking reimbursement for an additional 310 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.[19]

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[18] As discussed *infra*, this filing cannot be considered the "Provider's (Optional) Responsive Brief" as it was not filed in response to the arguments and evidence submitted in the Medicare Contractor's final position paper and was not filed consistent with Board Rules 27.3 and 27.4 governing such responsive briefs. *See also* Board Rule 35.3.
[19] Appeal Request at Issue 1.

Regarding the Medicaid eligible days issue, the Provider merely repeats verbatim the arguments in its issue statement in both its Preliminary Position Paper and Final Position Paper. However, as noted previously, the number of Medicaid Eligible Days in dispute in the initial appeal request and preliminary position paper is 310; while the number of Medicaid Eligible Days in dispute in the final position paper is 9,756. The Exhibit List included with the Final Position Paper includes the first listing submitted of days in dispute (albeit a fatally flawed listing). It is labeled "Medicaid Eligible 1115 Waiver Days". Finally, the March 18, 2024, supplemental filing by QRS identifies the listing as "Redacted Medicaid Eligible Days Listing" and the listing is entitled "Additional ME & 1115 Waiver Days" but fails to identify which days are § 1115 waiver days (if not all days). Although not specified, the number of days in dispute in this listing adds up to 20,036 days.

Medicare Contractor's Request for Dismissal

The Medicare Contractor contends that the Provider is attempting to untimely and improperly add the issue of Section 1115 waiver days as a sub-issue via its final position paper, filed on January 17, 2024.[20] The Medicare Contractor asserts that prior to the final position paper, the Provider had not formally added the dispute to the appeal, nor had it otherwise raised the issue of section 1115 waiver days.[21] The Medicare Contractor contends that the Provider's attempt to add the issue within its final position paper is improper and untimely, citing 42 C.F.R. § 405.1835(e), which governs when specific Medicare payment issues may be added to the original hearing request, including a timeframe of no later than 60 days after the expiration of the applicable 180-day deadline to file an appeal.[22]

The Medicare Contractor contends that the section 1115 waiver days issue is one component of the DSH issue. The Medicare Contractor contends that section 1115 waiver days issue is a separate and distinct issue from Medicaid eligible days issue and must be identified and appealed separately.[23]

Finally, the Medicare Contractor requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> 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 and final position papers. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.

[20] Jurisdictional Challenge at 8 (Feb. 20, 2024).
[21] *Id*. at 9.
[22] *Id*.
[23] *Id*. at 10.

> Within its preliminary and final position papers, the Provider fails 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 their appeal request.[24]

Provider's Response to the Dismissal Request

The Provider argues that in their initial appeal request, they "appealed all Medicaid eligible days, including section 1115 waiver days".[25] In support of its position, the Provider points the appeal statement reads, in pertinent part:

> 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.[26]

The Provider goes on to argue that Board Rules requiring components be appealed as separate issues does not apply and, in support, points to *the July 1, 2015 version* of Board Rule 8:

> Because Rule 8 purports to comply with what is in the regulations; and because the regulations deal with appealing issues, not "components" of issues, and because the regulations consider an "issue" to be a specific cost report adjustment, Rule 8's extension to "components" is not consistent with the regulations and is invalid because it is based on a false premise.
>
> Neither "section 1115 waiver days" nor even "Medicaid eligible days" are mentioned in Rule 8. Thus, even if Rule 8's extension to "components of issues" were valid (and the Provider contends it is not), the Provider had no notice that it was required to specify section 1115 waiver days in its appeal request, and it would be denial of due process for the PRRB to dismiss the section 1115 waiver days component of its appeal of Medicaid eligible days.
>
> The fact that the PRRB subsequently modified Rule 8 to mention specifically section 1115 waiver days indicates that the 2015 version of the PRRB's Rules did not contemplate that Plaintiff was required to include the magic language of "section 1115 waiver days" in its appeal request.[27]

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[24] *Id*. at 6.
[25] Jurisdictional Response at 1 (Mar. 18, 2024).
[26] *Id*. (Emphasis included).
[27] *Id*. at 3.

The Provider also argues that it has not abandoned the § 1115 waiver days as "the Provider discusses section 1115 waiver days extensively in its Final Position Paper."[28] The Provider also contends that the Medicare Contractor's argument that the Provider did not brief the § 1115 waiver days in its Preliminary Position Paper is "not a jurisdictional argument and is inappropriate for a jurisdictional challenge."[29]

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. DSH Payment – Medicaid Eligible Days

1. *Medicaid Eligible Days*

In its appeal request, the Provider stated that it "is seeking reimbursement for an additional 310 Medicaid Eligible Days" and that "Of the additional 310 days, ***all days*** *relate to the eligibility identified* ***subsequent to cost report being filed but before cost report was finally settled***."[30] In its preliminary position paper, the Provider restated that it is seeking an additional 310 Medicaid eligible days and again recognizes that "Of the additional 310 days, ***all days*** *relate to the eligibility identified* ***subsequent to cost report being filed but before cost report was finally settled***."[31] Notwithstanding the fact that all of the 310 days allegedly at issue had been identified prior to the cost report being settled, the Provider did not include a list of the specific additional Medicaid eligible days in dispute in either the initial appeal or the preliminary position paper.

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

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

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

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[28] *Id*.
[29] *Id*.
[30] (Emphasis added.)
[31] Provider's Preliminary Position Paper at 3.

> (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.[32]

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

> **Rule 25 Preliminary Position Papers**[33]
>
> **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 The Provider's Position Paper**

[32] (Bold emphasis added.)
[33] (Underline emphasis added to these excerpts and all other emphasis in original.)

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
C. Identify the controlling authority (e.g. statutes, regulations, policy, or case law) supporting the provider's position.
D. Provide a conclusion applying the material facts to the controlling authorities.

25.2 Position Paper Exhibits

25.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

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

25.3 Filing Requirements to the Board

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

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

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on August 29, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-referenced Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 1, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(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.[34]

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

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

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

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

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

[34] (Emphasis added.)

- upon failure to appear for a scheduled hearing.

In their initial appeal request and repeated in the August 23, 2020 filing of their preliminary position paper, the Provider did ***not*** include *the material fact* of identifying the specific 310 Medicaid eligible days being generically referenced in the appeal request and the preliminary position paper, but rather continued to reference the "estimated impact" included with its appeal request (*i.e.*, the estimated impact of $36,149 based on an "at this time" estimated 310 days). The Provider's complete briefing of this issue in its position paper is as follows:

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> 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.
>
> HMH is seeking reimbursement for an additional 310 Medicaid Eligible days. The Provider, in this appeal, contends that the documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report.
>
> **1. A Detailed Description Of The Process That The Provider Used To Identify And Accumulate The Actual Medicaid Paid And Unpaid Eligible Days That Were Reported And Filed On The Medicare Cost Report At Issue.**
>
> In summary, HMH matches its internal patient account details against the State Medicaid Eligibility file available at the time of preparing/filing costs to identify Medicaid eligible days.
>
> During patient's registration process, patients' insurance (governmental and commercial) information is verified and recorded in the patients' account records. All patients were advised of the charity assistance policy, as well as potential Medicaid qualification.

HMH also assists patients with Medicaid application when patients indicated interests.

HMH uses Meditech system ("Meditech") to accumulate all patient records, including but not limited to patient demographic information and medical record (admission date, discharge date, insurance, DRG, etc.). Meditech generates monthly and annual reports which show patient days/admissions in total as well as by insurance plan. An annual Meditech detailed data file is also generated to include detailed patient demographic information and medical records. The annual Meditech detailed data file is then validated against an annual Meditech summary report to ensure the completeness and accuracy of the detailed data file.

After validation, the detailed data file is then uploaded to a secure portal owned by Trinity, an outside service consultant, which then processes the data against the Medicaid Eligibility data file and returns a report of Medicaid eligible days to be included in the cost report DSH calculation (Trinity data matching). Trinity has access to multiple States' Medicaid records and this allows HMH to identify as many days as possible by the time of cost report filing. In the case when Trinity does not have access to a specific State's Medicaid record, HMH will work with Trinity to apply for the access to the specific State's Medicaid record. This process may take several weeks.

As Medicaid Eligibility data file is a dynamic database and changes as new beneficiaries are added or current beneficiaries are dropped, HMH normally requests Trinity data matching close to the cost report filing deadline to capture as many eligible days as possible. For the 2014 cost report, the Trinity matching was done in April 2015. However, in spite of performing the eligibility process described, HMH was unable to include all eligible days in the cost report for various reasons outside of their control. For example, many patients have their Medicaid status pending and coverage was retroactively determined months or sometimes even years after the cost report was filed. There are numerous other reasons why a patient day cannot consistently be determined to be eligible by the filing date of the cost report. In any event, as already stated, it is beyond the Provider's ability to determine just why patient days or any particular patient day could not be matched by the State as eligible at one point in time (in this case, by the date of the cost report filing), but subsequently is matched as eligible by the State.

As noted above, practical impediments precluded the identification of all additional Medicaid Eligible Days. It is impossible for the

Provider to claim all of its Medicaid Eligible Days at the time of filing its cost report.

2. The Number Of Additional Medicaid Paid And Unpaid Eligible Days That The Provider Is Requesting To Be Included In The DSH Calculation.

Medicaid Eligible Days results change over time. For this reason, providers generally prefer to prepare listings as close in time to a Hearing, Audit or Settlement as possible. Accordingly, the number expressed here may not be the number presented at hearing or settlement, but at this time the Provider is seeking to include an additional 310 Medicaid Eligible Days in its cost report.

3. **A Detailed Explanation Why The Additional Medicaid Paid And Unpaid Eligible Days At Issue Could Not Be Verified By The State At The Time The Cost Report Was Filed.**

Due to the limitation on Medicaid database, HMH/Trinity was unable to determine eligibility for several patients and; therefore, decided to exclude such patient days from the DSH calculation in originally filed cost report.

The most common circumstance in which the State of Texas Medicaid agency is unable to verify Medicaid eligible days involves the retroactive eligibility situation. An individual's eligibility for Medicaid commences on the date of her/his application to the program, assuming that individual meets the eligibility qualifications for Medicaid at the time of application submission. However, there is frequently considerable lag time between the date on which an individual submits her/his application for Medicaid, and the date on which that individual is determined to be eligible for the program. This lag time typically involves several months, and in some cases, several years. In this circumstance, the State of Texas Medicaid agency will not have the data to verify an individual's eligibility for Medicaid as of the date of the Provider's filing of its Medicare cost report. Of the additional 310 days, all days relate to the eligibility identified subsequent to cost report being filed but before cost report was finally settled.

CONCLUSION

The Provider contends that the Board does have jurisdiction as the protesting/presentment requirement does not apply. Furthermore, even should the Board determine that the presentment requirement

> does apply the Provider respectfully contends that it does not apply in this situation as DSH is not an item that must be adjusted or even claimed on a cost report, which is further supported by the reasons the Provider gave as to the availability of data at the time of the filing of the cost report. In addition, even if the Board finds the presentment requirement is applicable, the MAC adjusted the Provider's DSH percentage. Accordingly, the Provider contends that the requirements for dissatisfaction have been met. Finally, the Provider challenges the validity of Alert 10.
>
> Audit Adjustment Number(s): 35
> Estimated Reimbursement Amount: $36,149

In its February 20, 2024 dismissal request (as well as it final position paper), the Medicare Contractor asserts that the Provider has failed to submit a list of additional Medicaid eligible days and 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 Rules.

Finally, on January 17, 2024, the Provider included what it claimed is a "Detail Listing of Medicaid Eligible 1115 Waiver Days Log"; however, as discussed *supra*, the listing did ***not*** include sufficient information to be auditable (*e.g.*, it did not include any patient identifying information such as account number or patient name). Further, the Final Position Paper included identical language to the prior Issue Statement and Preliminary Position Paper but for now seeking reimbursement for an "at this time . . . additional 9,756 Medicaid Eligible Days" with an "Estimate Reimbursement Impact" of $1,200,803. Significantly, the final position paper did ***not*** explain why any § 1115 waiver days should be included in the numerator of the Medicaid fraction. Indeed, it did not even mention that § 1115 waiver days were in dispute much less identify what specific § 1115 waiver program was involved.

The Medicare Contractor filed subsequently filed a Jurisdictional Challenge requesting dismissal of Issue 1, the DSH Medicaid Eligible Days issue, as discussed above. The Medicare Contractor 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 failed to produce those documents, as required by the regulations and the Board Rules.[35]

However, on March 18, 2024 (just less than two months after the final position paper deadline), QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission." This listing included 20,036 days (exponentially more than the initial 310-day estimate and more than double the 9,756-day listing sent merely two months prior as part of the final position paper) and did not include any estimate of reimbursement impact. QRS' filing did not explain why the listing of so many days (over 20,036 days) was being submitted at this late

[35] *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.

date, ***more than 9 years after the fiscal year at issue had closed***. Additionally, the Provider did not explain why the 20,036 included in this belated listing is *exponentially* larger than the original estimate of 310 days included with the appeal request. Regardless, this filing ***was also almost than two months past the deadline for including it with its final position paper*** since the position paper deadline was January 19, 2024.

The Board must concur with the Medicare Contractor that the Provider is required to identify *the material facts* (*i.e*., the number of days at issue and specifically identify those days consistent with its burden of proof under 42 C.F.R. § 412.106(b)(4)(iv)) and provide relevant supporting documentation to identify and prove the specific additional Medicaid Eligible days at issue and for which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rule 25, and 42 C.F.R. § 412.106(b)(iii). Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable. The Board finds that the Provider also failed to fully develop the merits of the Medicaid eligible days issue because the provider has failed to identify any specific Medicaid eligible days at issue (much less any supporting documentation for those days). QRS filed the new evidentiary exhibit without the express consent of the Medicare Contractor and failed to explain why the new exhibit was being submitted on an untimely basis notwithstanding the requirements for filing the final position paper stated in the Notice of Hearing, Board Rules 25, 27 and 35.3, and 42 C.F.R. § 405.1853(b)(2)-(3).

The Board is baffled as to why the Provider, *without explanation*, has failed to timely identify the specific days at issue in this case. This case involves FY 2014 and the appeal of that fiscal year was filed on February 28, 2019, more than 4 years after that fiscal year had been closed. In the final rule published on November 13, 2015, the Secretary stated her belief that "12 months [after the hospital's fiscal year end] is sufficient time for states to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment."[36] As a result, it remains unclear why the Provider could not identify the specific days at issue when it filed its preliminary position paper on April 23, 2020 when that filing was made ***more than 6 years*** *after the fiscal year at issue had ended*. Indeed, the Provider has failed to explain why at this late day it is now claiming 20,036 days instead of the original 310 days (which was never detailed and then abandoned in the final position paper since the final position paper only included a listing of 9,756 § 1115 waiver days[37]).

The fact that, on March 18, 2024, QRS filed a new Listing apparently supplement Exhibit P-1 after the Provider changed its designated representative to QRS does not excuse the Provider for its failure to include this exhibit (and related information) with its preliminary position paper (or even final position paper). Board Rule 5.2 makes clear that "the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings." Moreover, the Board rejects the Provider's attempt to label the March 18, 2024 filing as a "Supplement to Position Paper" and does not accept that filing as a supplement to Exhibit P-1 because:

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[36] 80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).
[37] Again, this so-called listing is fatally flawed in that it is not an auditable listing as discussed *supra*.

1. The alleged "Supplement" to Exhibit P-1 was filed ***almost two months*** *after the deadline* for that exhibit to be included with its final position paper filing consistent with Board Rule 25.2.2 (as authorized by 42 C.F.R. § 405.1853(b)(3)).

2. The alleged "Supplement" Exhibit fails to explain the following critical information: (a) *why* it was being filed so late (*i.e*., upon what basis or authority should the Board accept the late filing); (b) *why* the listing of the over 20,036 days was not previously available, *in whole or in part* (*i.e*., it is not clear why the Provider failed to specifically identify ***for the record*** a single day at issue until more than 4 years after this appeal was filed and more than 9 years after the fiscal year at issue had closed); and (c) whether the listing is a "*final*" listing at this late date (since there have been two different *alleged* listings and three different estimates). Indeed, if it is a "Supplement" to Exhibit P-1 does that mean that the Provider is still claiming the 9,756 days identified in Exhibit P-1 and then an additional 20,036 days in the "Supplement" Exhibit. The Provider gives no explanation.

3. Neither the Board Rules nor the August 10, 2023 Notice of Hearing and Critical Due Dates permit the Provider to file a "Supplement" Exhibit to its final position paper (nor did the Provider allege in the "Supplement" Exhibit filing that they do).[38]

4. Given the fact that the *material* facts (*e.g*., the days at issue) and all available exhibits were required to be part of the position paper filing, if the Board were to accept a "Supplement," it would need to be either be a *refinement* of the arguments in its preliminary position paper or a supplement of documents that were identified in the preliminary position paper as being unavailable consistent with Board Rule 25.2.2. However, neither the preliminary position paper nor the alleged "Supplement" identified any "unavailable" exhibits consistent with Board Rule 25.2.2. Further, the alleged "Supplement" cannot be considered a refinement of the arguments in its position paper since this filing is "Supplement" Exhibit to augment Exhibit P-1.[39]

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[40] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

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[38] The Provider was permitted to file a Optional Responsive Brief to the arguments and evidence submitted in the Medicare Contractor's final position paper. But that is not what the March 18, 2024 Supplement was as it was clearly an Exhibit not a position paper and was meant either to replace or supplement the Exhibit P-1 that was attached to the Provider's final position paper.

[39] *See, e.g.,* Board Rule 27.3 (Aug. 2018) stating: "Except on written agreement of the parties, revised or supplemental position papers should not present new positions, arguments or evidence."

[40] (Emphasis added.)

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its preliminary position paper and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the specific days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[41] Indeed, the Provider even failed to do that with its final position paper filing as the specific days at issue still were not identified.

2. *Section 1115 Waiver Days*

As set described below, the Board finds that: (1) the § 1115 waiver days issue is a separate issue and it is not a part of this appeal because it was not properly or timely added; and (2) even if it were an issue in this appeal, it was abandoned since the merits of the issue and material facts were not briefed in the preliminary position paper (or even in the final position paper).

The Provider failed to include § 1115 waiver days as a cost issue in its appeal request and failed to timely and properly add this additional issue to the appeal. While the Provider appealed Medicaid eligible days, this issue is separate and distinct from the § 1115 waiver days as recognized by multiple Board, Administrator and Court decisions[42] as well as the Board's Rules in in effect when the appeal for this case was filed (specifically Board Rule 8 (Aug. 2018)).

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

> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.

[42] *See, e.g.*, *QRS 1993-2007 DSH/Iowa Indigent Patient /Charity Care (GA) Group v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Jan. 15, 2013), *affirming* PRRB Dec. No. 2013-D02 (Nov. 21, 2012)*; St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, No. 3:12-cv-832, 2014 WL 8515280 (S.D. Miss. 2014); *Singing River Health Sys. v. Novitas Solutions, Inc.*, PRRB Dec. 2016-D19 (Sept. 20, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016); *CCT&B 2005-2006 Hurricane Katrina § 1115 Waiver UCP Days Grp. v. Novitas Solutions, Inc*., PRRB Dec. 2016-D18 (Sep. 16, 2016), *rev'd* CMS Adm'r Dec. (Nov. 18, 2016), *aff'd sub nom. Forrest Gen. Hosp. v. Hargan*, No. 2:17-CV-8, 2018 WL 11434575 (S.D. Miss. Feb. 22, 2018), *rev'd & remanded Forrest Gen. Hosp. v. Azar*, 926 F.3d 221 (5th Cir. 2019); *Southwest Consulting UMass Mem'l Health Care & Steward Health 2009 DSH CCHIP Section 1115 Waiver Days Grps. v. Nat'l Gov't Servs., Inc*., PRRB Dec. 2017-D04 (Jan. 27, 2017), *rev'd* CMS Adm'r Dec. (Mar. 21, 2017), *vacated & remanded sub nom*. *HealthAlliance Hosps., Inc. v. Azar*, 346 F. Supp. 3d 43 (D.D.C. Oct. 26, 2018); *Florida Section 1115 LIP Rehab DSH Waiver Days Grps. v. First Coast Serv. Options*, PRRB Decs. 2018-D21, 2018-D22 (Feb. 8, 2018), *vacated by* Adm'r Dec. (Mar. 30, 2018), *rev'd by Bethesda Health Inc. v. Azar*, 389 F. Supp. 3d 32 (DDC 2019), *aff'd by* 980 F.3d 121 (D.C. Ci;r. 2020).

The appeal was filed with the Board in August of 2019 and the regulations at 42 C.F.R. § 405.1835(b) required the following content to be include in an appeal request:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing…must be submitted in writing to the Board , and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> ****
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final…determination under appeal, including an account of….
>
> (i) why the provider believes Medicare payment is incorrect for each disputed item...[and]
>
> (ii) how and why the provider believes Medicare payment must be determined differently for each disputed item…[43]

Board Rule 7.2.1 elaborated on this regulatory requirement instructing providers:

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

Board Rule 8 explains that when framing issues for adjustments, some issues may have multiple components and "[t]o comply with the regulatory requirement to *specifically* identify the items in dispute [*see* 42 C.F.R. § 405.1835(b)], each contested component must be appealed as a separate issue and described *as narrowly as possible* using the applicable format outlined in Rule 7."[44] The Rule goes on:

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[43] 42 C.F.R. § 405.1835(b).
[44] (Emphasis added.)

> Several examples are identified below, but these examples are *not exhaustive* lists of categories or issues.
>
> **A. Disproportionate Share Hospital Payments**
>
> *Common examples include*: dual eligible Medicare Part A/Medicaid, dual eligible Medicare Part C/Medicaid, SSI data matching, state/program specific general assistance days, *Section 1115 waiver days (program/waiver specific)*, and observation bed days.[45]

As noted in the Rule, the list provides examples and is not exhaustive. In this regard, the Provider should have been on notice that the 1115 waiver day issue is a separate issue due to the significant litigation around the issue.[46]

In the Provider's Jurisdictional Response, the Provider *erroneously* cites the 2015 version of the Board's Rules, and points out that this earlier version does not specifically name § 1115 waiver days as a common example component issue.[47] However, the Instant Appeal was filed in August of 2019 and, therefore, the Board Rules in effect is v. 2.0, effective August 29, 2018. As noted above, these Rules do *specifically* mention § 1115 waiver days.

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[48] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> ****
>
> (2) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

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

In this regard, the Board noted that § 1115 waiver days are not traditional Medicaid eligible days and indeed were only incorporated into the DSH calculation effective January 20, 2000.[49]

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[45] (Italics and underline emphasis added).
[46] *See* listing of cases in *supra* note 42.
[47] *Supra* note 27 and accompanying text.
[48] *See* 73 Fed. Reg. 30190 (May 23, 2008).
[49] 65 Fed. Reg. 47054, 47087 (Aug. 1, 2000).

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

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

> (4) *Second computation*. (1) The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan **or under a waiver authorized under section 1115(a)(2) of the Act** on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> **(ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Because the Provider did not raise the § 1115 Waiver days prior to the deadline to add issues, and it is a distinct issue, the Board find that the issue was not properly or timely appealed. The DSH Medicaid Eligible Days issue as stated in the original appeal request cannot be *properly* construed under 42 C.F.R. § 405.1835(b) and Board Rule 8 to include the § 1115 waiver days issue.[50]

---

[50] The Board recognizes that the appeal request states that "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." However, the immediate next sentence is: "[The Provider] is seeking reimbursement for an additional 310 Medicaid Eligible days" and that "The Provider, in this appeal, contends that the

Additionally, there is no indication that any 1115 waiver days were included with the as-filed cost report which, if true, would make them an unclaimed cost and provide an independent basis for dismissal. In raising this issue, the Board notes that it has found that when a class of days (*e.g.*, 1115 waiver days) is excluded due to choice, error, and/or advertence from the as-filed cost report,[51] then that class of days is an unclaimed cost for which the Board would lack jurisdiction under 42 U.S.C. § 1395oo(a) consistent with CMS Ruling 1727-R.[52] The Provider's position papers do not discuss this jurisdictional issue even though 42 C.F.R. § 405.1853(b)(2) requires position papers to address the Board's jurisdiction over each issue. This is an independent basis for the Board to dismiss the § 1115 waiver days issue (*i.e.*, in addition to and independent from dismissal for failure to properly include the issue in its appeal request).

Finally, the Board notes that, even if the § 1115 waiver days issue were properly part of this appeal (which it is not), the Provider failed to properly brief the issue (much less mention it) in the Provider's preliminary position paper contrary to the instructions/requirements included in the August 29, 2019 Notice of Case Acknowledgement and Critical Due Dates, Boar Rule 25, and 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv). Similarly, ***contrary to QRS' assertion in its*** , the Provider failed to properly brief the § 1115 waiver days issue in its final position paper. While the Exhibit P-1 attached to the final position paper is entitled "Detail Listing of Medicaid Eligible 1115 Waiver Days Log", the final position paper itself does not discuss much less mention the § 1115 waiver day issue (*e.g.*, identify the *specific* State § waiver program at issue and why days for *that specific* program qualify under 42 C.F.R. § 412.106(b)(4) to be counted in the numerator of the DSH Medicaid fraction).[53] Indeed, the so-called listing included as Exhibit P-1 is fatally flawed as it is not auditable as discussed *supra*.

---

documentation necessary to pursue DSH was not available from the State of Texas in time to include all DSH/Medicaid Eligible Days on the cost report." Moreover, the "including but not limited to" phrase only pertained to traditional Medicaid eligible days and reasons why they may not have been included in the fraction. It did not expand to include other classes of days such as general assistance, State-only days or § 1115 waiver days. A generic catchall phrase cannot be used to essentially shoehorn in the later addition of an issue on an ***untimely*** basis in contravention of Board Rules and regulations.

[51] CMS Transmittal 11912 (Mar. 16, 2023) makes clear that hospitals are responsible for maintaining records of their 1115 waiver patients:

> Each provider with an approved Section 1115 waiver program ***has a method for identifying the days*** that are applicable to such waiver for reimbursement from the Medicaid program. As such, ***the provider is responsible for maintaining the appropriate supporting documentation*** *for the accrual of the days associated with Section 1115 waiver reimbursements*. Providers *typically keep this information in the form of a listing* of specific patient accounts for each individual acute hospital stay (Section 1115 log) that is subject to Section 1115 reimbursement. This Section 1115 log is similar to a provider's DSH Medicaid eligible days listing.

(Emphasis added.)

[52] *See, e.g.,* PRRB Jurisdictional Decision, Case Nos. 06-1851, 06-1852 (Nov. 17, 2017) (dismissing the class of adolescent psychiatric days from the appeal because no days were claimed with the as-filed cost report due to choice, error and/or inadvertence and, as such, the practical impediment standard or futility concept in the *Norwalk* and *Danbury* Board decisions under PRRB Dec. Nos. 2012-D14 and 2014-D03 is not applicable) (available at: https://www.cms.gov/regulations-andguidance/review-boards/prrbreview/downloads/jd-2017-11.pdf (last accessed Dec. 15, 2023)).

[53] *See supra* note 42 (list of cases discussing the merits of complex and fact-specific arguments raised by providers in appeals of *specific* State § 1115 waiver programs).

In summary, the Board finds that: (1) the § 1115 waiver days issue is a separate issue and it is not a part of this appeal because it was not properly or timely added;[54] and (2) even if it were an issue in this appeal (which it is not), it was abandoned since the merits of the issue and material facts were not briefed in the preliminary position paper (or even in the final position paper). Accordingly, for the multiple and independent bases, the Board dismisses the § 1115 waiver day issue from this appeal.

* * * * *

In summary, the Board dismisses the DSH Payment - Medicaid Eligible Days issue in its entirety (including the alleged 1115 waiver days sub-issue) based on multiple independent bases related to the Provider's noncompliance with 42 C.F.R. §§ 405.1835(b), 405.1853(b)(2)-(3), and 412.106(b)(4)(iii) and Board Rules 7, 8, 25, and 27 (as well as the instructions included in the Board's Notices issued on August 29, 2019 and August 10, 2023). Accordingly, the Board here by closes Case No. 19-2505 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/17/2024

X Clayton J. Nix

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

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

[54] The fact that, as a result of the *Bethesda and Forrest General* decisions, the Secretary may ***now*** (well after the appeal request was filed) have changed its stance on how *certain* § 1115 waiver days may or may not be included in the numerator of the Medicaid fraction does *not* otherwise alter the base requirement that the Provider must have a claim for that issue *properly* pending in an appeal in the first instance. Moreover, CMS Transmittal No 11912 at 5 (Mar. 16, 2023) does reference the requirement that a Provider have a properly pending appeal of the issue: "jurisdictionally valid pending Section 1115 Bethesda-like appeals." As such, the Board finds that Medicare Contractors are ***not*** obligated to accept or review any and all claims for § 1115 waiver days but rather only those where a "Section 1115 Bethesda-like appeal" is *properly* pending before the Board. Indeed, this is a basic mantra of CMS included in CMS Rulings generally. *See, e.g.*, CMS Ruling 1498-R (Apr. 28, 2010) ("In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each properly pending DSH appeal of the SSI fraction data matching process issue, by applying…."); CMS Ruling 1739-R (Aug. 17, 2020) ("First, it is CMS's Ruling that the agency and the Medicare contractors will resolve each properly pending claim in a DSH appeal in which a provider alleges that . . . ."). Regardless, that Transmittal is not directed to the Board itself or Board proceedings and, to this end, does not give any guidance or instruction *to the Board*.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Haider Andazola
Associate
Foley Hoag, LLP
1717 K Street, NW
Suite 1200
Washington, DC 20006

RE: Boston Medical Center Corporation
Provider Number: 22-0031
Appealed Period: FYE 09/30/2023
PRRB Case Number: 24-1755

Dear Mr. Andazola:

On April 9, 2024, the Provider filed an appeal for its Fiscal Year End ("FYE") 9/30/2023 via the Office of Hearings Case and Document Management System ("OH CDMS"). The Board's review and determination regarding the filing of the above-captioned appeal is set forth below.

RULES/REGULATIONS:

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

The appeal is also governed by the following Board rules:

> 4.3.1 **Commencement of Appeal Period**
> The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. See 42 C.F.R. § 405.1801(a)(1)(iii). The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.
>
> 4.4.1. **Due Dates for New Appeals**
> New appeals must be received by the Board no later than 180 days from the commencement of the appeal period as specified in Rule 4.3. …
>
> 4.4.3 **Due Date Exceptions**
> If the due date falls on a Saturday, a *Sunday*, a federal legal holiday, (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on

which the Board is unable to conduct business in the usual manner (e.g., "if OH CDMS were down for the entire last day of a deadline" (85 Fed. Reg. 58432, 58987 (Sept. 18, 2020))), the deadline becomes the next day that is not one of the aforementioned days. See 42 C.F.R. § 405.1801(d)(3).

4.5 **Date of Receipt by the Board**
The timeliness of a filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be: A. The date of filing in OH CDMS as evidenced by the Confirmation of Correspondence generated by the system; …

BOARD DETERMINATION:

After review of the case, the Board has found that the final determination, upon which the appeal is based, is dated October 5, 2023. Allowing for a five-day mailing presumption for receipt of the final determination, the applicable appeal period ran from Tuesday, October 10, 2023, through Sunday, April 7, 2024 (180 days). Because this due date fell on a weekend, the deadline was extended by one additional day to Monday, April 8, 2024.

The date of receipt by the Board, as evidenced by the Confirmation of Correspondence generated by OH CDMS, was Tuesday, April 9, 2024. The Provider missed the 180-day deadline by one day.

Therefore, the Board has determined that the subject individual appeal was not timely filed within the parameters set forth in 42 C.F.R. § 405.1835(a)(3) and the Board Rules referenced above. The Board hereby dismisses case number 24-1755.

Board Members:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole Musgrave, Esq.

FOR THE BOARD:

4/24/2024

X Ratina Kelly

Ratina Kelly, CPA
Board Member
Signed by: Ratina S. Kelly -S

cc: Wilson C. Leong, Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Daniel Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave. NW, Ste. 900
Washington, DC 20006

Byron Lamprecht
WPS Government Health Administrators
1000 N 90th St., Ste. 302
Omaha, NE 68114-2708

RE: ***Dismissal Decision***
St. Luke's Hospital of Kansas City, Prov. No. 26-0138, FYE 12/31/2015
Case No. 19-0553

Dear Messrs. Hettich and Lamprecht:

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

Background

A. General Procedural History in Case No. 19-0553

On December 21, 2018, Quality Reimbursement Services ("QRS") filed a request for hearing on behalf of the Provider based on a Notice of Program Reimbursement ("NPR") dated July 3, 2018. The Provider's appeal request included the following issues:

1. DSH SSI Provider Specific
2. DSH Medicaid Eligible Days
3. Direct Graduate Medical Education ("DGME") Penalty to FTE Count
4. IPPS Understated Standardized Payment Amount[1]
5. DSH Medicaid Fraction Dual Eligible Days[2]
6. DSH Medicaid Fraction Medicare Managed Care Part C Days[3]
7. DSH SSI Percentage[4]

[1] Issue 4 was transferred to Case No. 19-0566GC. But as the CIRP group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-0604G.
[2] Issue 5 was transferred to Case No. 19-0565GC. But as the CIRP group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-2596G.
[3] Issue 6 was transferred to Case No. 19-0564GC. But as the CIRP group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-2595G.
[4] Issue 7 was transferred to Case No. 19-0561GC. But as the CIRP group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-2592G.

8. DSH SSI Fraction Medicare Managed Care Part C Days[5]
9. DSH SSI Fraction Dual Eligible Days[6]

On January 23, 2019, the Board acknowledged appeal and set deadlines for the parties' preliminary position papers. This notice also gave the following instructions regarding the content of the provider's preliminary position paper:

> Provider's Preliminary Position Paper – ***For <u>each</u> 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.[7]

On August 15, 2019, QRS timely filed the Provider's preliminary position paper.

On November 3, 2019, the Medicare Contractor filed a Jurisdictional Challenge requesting that the Board dismiss Issue 3. On December 5, 2019, QRS timely filed its response to the Jurisdictional Challenge.

On December 13, 2019, the Medicare Contractor filed its preliminary position paper.

On December 17, 2019, QRS transferred Issues 4 to 9 (*i.e.*, six issues) from this appeal to various single participant CIRP groups for St. Luke's Health. However, between December 18, 2019 and January 21, 2020, these issues ultimately ended up in optional groups as the CIRP groups were fully formed with only one participant.[8]

On February 8, 2023, QRS withdrew Issues 1[9] and 2, *leaving Issue 3 as the* ***sole remaining issue***.

On March 7, 2023, the Provider's designated representative was changed from QRS to King & Spalding, LLP ("K&S").

---

[5] Issue 8 was transferred to Case No. 19-0562GC. But as the CIRP group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-2593G.

[6] Issue 9 was transferred to Case No. 19-0563GC. But as the CIRP group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-2594G.

[7] (Emphasis added).

[8] *See supra* notes 1-6.

[9] On March 5, 2019, the Medicare Contractor filed a jurisdictional challenge over Issue I in the appeal. On March 28, 2109, QRS filed a jurisdictional response. That challenge is now moot as the Provider withdrew Issue 1 on February 8, 2023.

On October 11, 2023, the Board issued the Notice of Hearing setting the June 27, 2024 hearing date and setting deadlines for the parties' final position papers. The Notice included the following instructions regarding the content of the Provider's final position paper:

> Provider's Final Position Paper – **For <u>each</u> remaining issue**, the position paper **<u>must</u> 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.[10]

On March 29, 2024, K&S filed the Provider's final position paper. Similarly, on April 15, 2024, the Medicare Contractor filed its final position paper.

B. Procedural History for Issue 3 – the Sole Remaining Issue in Case No. 19-0553

In its December 21, 2018 appeal request, the Provider described Issue 3 as follows:

> **<u>Statement of the Issue</u>**
>
> Whether the Medicare Administrative Contractor ("MAC") must correct its determination of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").
>
> **<u>Statement of the Legal Basis</u>**
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP. 42 U.S.C. § 1395ww(h)(4)(C). CMS's implementation of the cap and weighting factors is contrary to the statute because it imposes on the Provider a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Provider from claiming FTES up to its full FTE cap. See 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payments consistent with the statute so that the DGME cap is set at the number of FTE residents that the Provider trained in its most recent cost reporting period ending on or before December 31, 1996, and the residents beyond the IRP are weighted at no more than 0.5. The Provider self-disallowed this item because the

[10] (Footnote omitted, italics emphasis in original, and bold and underline emphasis added.)

> Provider challenges the regulation at 42 C.F.R. § 413.79(c)(2), and the MAC is bound by that regulation.

On August 15, 2019, the Provider filed a Preliminary Position Paper.

On November 5, 2019 the Medicare Contractor filed a jurisdictional challenge, in which it requested dismissal of Issue 3. As part of this challenge, the Medicare Contractor asserts that the Provider improperly added the issues of understated indirect medical education ("IME") full-time equivalent ("FTE") counts and PRA amounts via its preliminary position paper, rather than timely appealing the issues through their appeal request.

On December 5, 2019, QRS timely filed the Provider's response to the Jurisdictional Challenge.

On March 29, 2024, K&S (*as the newly-appointed representative replacing QRS*) filed the Provider's final position paper. Significantly, the Provider's final position paper only briefs the GME FTE count issue challenging the treatment of fellows in the reimbursement formula at 42 C.F.R. § 413.79(c)(2)(iii) as it relates to the FTE counts for the Provider's present, prior and penultimate years as used in the NPR at issue. Further, the Provider's final position paper does not discuss or acknowledge the open request for dismissal of Issue 3.

Medicare Contractor's Jurisdictional Challenge filed on November 5, 2019

First, the Medicare Contractor asserts that the Provider has improperly expanded Issue 3 (the GME FTE issue) through its Preliminary Position Paper. The Medicare Contractor explains that the Provider described the GME FTE issue in the appeal request as follows:

> Whether the Medicare Administrative Contractor ("MAC") must correct its determination of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").

The Provider objected to the requirement to apply a 0.5 weighting factor to Graduate Medical Education (GME) full time equivalent (FTE) counts, applicable to residents training beyond the initial residency program. However, the Medicare Contractor maintains that the Provider's appeal request did not mention indirect medical education (IME) FTE counts or the Provider's GME per resident amount (PRA).[11]

The Medicare Contractor goes on to explain that the Provider described the issue as follows in its preliminary position paper:

> The provider contends that the MAC failed to apply the correct full time equivalent ("FTE") resident count in determining the GME and the indirect medical education adjustment ("IME"). Additionally, the MAC failed to apply the correct average per

[11] Medicare Contractor's Jurisdictional Challenge at 4.

> resident amount ("APRA") in determining the direct graduate medical education payment ("GME").[12]

The Medicare Contractor then notes that the Provider states its position with respect to the FTE Count and APRA as follows:

> The Provider will demonstrate in its hearing before the Board that the FTE count applied by the MAC is inappropriate…The Provider will demonstrate in its hearing before the Board that the MAC did not compute the APRA as required by applicable law.[13]

The Medicare Contractor contends that the additional aspects of Issue 3, concerning the IME FTE counts and the Per Resident Amount (PRA) were not specifically discussed in the Provider's Request for Hearing. Accordingly, the Medicare Contractor asserts that the Provider must not be permitted to add the issues of IME FTE counts and the PRA to the appeal by simply presenting the issues in its preliminary position paper. The Provider failed to address the issues in their appeal request. In addition, the Provider did not add the issues in the time frame allowed. Thus, the Provider did not comply with 42 C.F.R. § 405.1835(a-e) and Board Rule 6.2.1.[14]

Finally, the Medicare Contractor contends that the Provider has abandoned Issue 3 as it was originally appealed, *i.e.*, the weighting of residents training beyond the IRP because the Provider failed to brief the DGME Penalty to FTE Count portion of Issue 3. The Board Rule at 25.1 requires providers' position papers to include various elements. In accordance with Board Rule 25.1.1(B) a provider must for each issue that has not been resolved, state the material facts that support the provider's claim. Furthermore, Board Rule 41.2 states that the Board may dismiss a case or an issue it has a reasonable basis to believe has been abandoned. Inasmuch as the Provider did not present any argument in support of their position, the Medicare Contractor maintains that the Board should dismiss the DGME Penalty to FTE Count portion of Issue 3.[15]

Provider's Jurisdictional Response filed by QRS on December 5, 2019

In its jurisdictional response, QRS states that the issue language in the Provider's individual appeal for direct graduate medical education covers both GME/IME and how it affects the FTE count in broad language and includes the IME FTE and PRA components of the issue.[16] NOTE—As the Provider abandoned these aspects of Issue 3 in its final position paper, its opposition to the Medicare Contractor's request for the Board to dismiss these aspects of Issue 3 is now moot.

QRS then inexplicably dives into a long discussion of the DSH payment and the presentment requirement.[17] *Significantly, QRS did* ***not*** *address the Medicare Contractor's contention that it abandoned the original DGME issue.* Indeed, it does not discuss the weighting of residents training beyond the IRP much less its original challenge to 42 C.F.R. § 413.79(c)(2).

[12] *Id.* at 5.
[13] *Id.* at 5.
[14] *Id.* at 5.
[15] *Id.* at 5.
[16] Provider's Jurisdictional Response at 1.
[17] *Id.* at 1-7.

Board's Decision

The Medicare Contractor has requested that the Board dismiss the IME FTE counts and the Per Resident Amount aspects of Issue 3 that QRS raised in the Provider's preliminary position paper. However, the Medicare Contractor's request is now moot because the Provider abandoned these aspects of Issue 3 (to the extent these aspects of Issue 3 were ever part of this appeal) since the Provider's final position paper (as filed by K&S) does not brief the merits of these aspects of Issue 3. 42 C.F.R. § 405.1853(b)(2) requires position papers to address the merits of each issue in an appeal. To this end, Board Rule 25.3 (Nov. 2021) specifies that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Accordingly, consistent with this regulation and Board Rule 25, the Board finds that the IME FTE count and PRA aspects of Issue 3 were effectively withdrawn from this appeal.

Regardless, to the extent these aspects had not been abandoned in the final position paper, the Board would have dismissed these aspect of Issue 3 consistent with 42 C.F.R. §§ 405.1835(b) and 405.1835(e) (Oct. 2018) because the Provider did not properly include the issue in the original appeal request and timely appeal the issues.

In order for an issue to be part an appeal request, the request must comply with the content requirements for requesting a Board hearing in an initial appeal.[18] Specifically, 42 C.F.R. § 405.1835(b)(2) (Oct. 2018) requires the following content be included in the appeal request:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and **the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section**. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, **the Board may dismiss with prejudice the appeal** or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is

[18] 42 C.F.R. § 405.1835(e).

> unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[19]

Significantly, the regulations confirms that failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[20]

The Board Rules reiterate the same requirements at Board Rule 7.2.1 by giving the following "General Information" on the content of an appeal request:

> The following information and supporting documentation must be submitted for each issue raised in the appeal request. • An issue title and a concise issue statement describing:
>
> - An issue title and a concise issue statement describing:
>
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - The basis for jurisdiction before the PRRB.
> - A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
> - A calculation or other support for the reimbursement effect noted in the issue statement.

[19] (emphasis added).
[20] 42 C.F.R. § 405.1835(b).

- Support for protested items or claim of dissatisfaction as noted in Rules 7.3 and 7.4.[21]

Additional guidance is located in Board Rule 8 on "Framing Issues for Adjustments Involving Multiple Components" such GME:

> **8.1 General**
>
> General Some issues may have multiple components. To comply with the *regulatory requirement to specifically identify* the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> ****
>
> **C. Graduate Medical Education/Indirect Medical Education**
>
> Common *examples* include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.[22]

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[23] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if –
>
> ****
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to St. Luke's appeal no later than 240 days after receipt of the Medicare Contractor's determination. In the instant case the deadline to add issues was February 28, 2019. St. Luke's first mention of the understated IME FTE counts and Per Resident Amount issues in this appeal was in its preliminary position paper submitted on August 15, 2019, well after the deadline to add issues to the appeal.

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[21] PRRB Rule 7.2.1 (Aug. 2018).
[22] (Italics and underline emphasis added and bold in original).
[23] *See* 73 Fed. Reg. 30190 (May 23, 2008).

Here, the Provider's appeal request does not discuss either IME or the Per Resident Amount issues (and to this end, the amount in controversy calculation does not specifically address these issues). Further, it made no filing subsequent to the appeal request with the time allotted under 42 C.F.R. § 405.1835(e) to add these issues. Accordingly, because the Provider did not raise the understated IME FTE counts and Per Resident Amount issues in its initial appeal request or add the issues to its appeal before the regulatory deadline, the Board finds that these issues were not timely appealed. Therefore, the Board would dismiss these aspects of Issue 3 if the Provider had not already abandoned these issues in its final position paper.

With respect to the original aspect of Issue 3, DGME Penalty to FTE Count issue, the Provider's appeal request challenges the Medicare Contractor's determination of the Provider's cap of FTE residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education. The Medicare Contractor requested that the Board dismiss the original aspect of Issue 3 because the Provider abandoned the issue by failing to brief it in its preliminary position paper.

In reviewing the Provider's preliminary position paper filed by QRS on August 15, 2019, the Board finds that the Provider failed to brief the original aspect of Issue 3 relating to the weighting of residents training beyond the IRP and the associated challenge to the regulation at 42 C.F.R. § 413.79(c)(2). In this regard, the Board notes that the preliminary position paper does not present any arguments regarding the weighting of residents, much less discuss or mention any challenge to § 413.79(c)(2). *In particular, the Provider's preliminary position paper does not address* ***any*** *of the arguments it makes in its final position paper*.

Board Rule 25 (Aug. 29, 2018) addresses Preliminary Position Papers:

> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must contain the elements addressed in the applicable sub-section.

> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, provide a ***fully*** developed narrative that:
>
> - States the material facts that support the provider's claim.
> - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
> - Provides a conclusion applying the material facts to the controlling authorities.
>
> C. Comply with Rule 25.2 addressing Exhibits.

Consistent with Board Rule 25, the Board's Acknowledgement setting the Provider's deadline for filing its preliminary position paper also includes instructions for the content of the Provider's preliminary position paper "[f]or each remaining issue" (as quoted *supra*).

Board Rule **25.3 Filing Requirements to Board** states that if the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn. The commentary to the rule states the following:

> Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868.[24]

Moreover, 42 C.F.R. § 405.1868 provides, in pertinent part:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board

[24] Similarly, the Commentary to Board Rule 23.3 states "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)."

> appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may –
>
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

The Board dismisses the DGME Penalty to FTE Count issue from the appeal as the Provider did not provide a fully developed narrative that states the material facts that support the Provider's claim, identifies the controlling authorities that support the Provider's position or provide a conclusion that applies the material facts to the controlling authorities.[25] Consistent with Board 42 C.F.R. § 405.1853(b)(2) and Rule 25, the Board considers the unbriefed issue abandoned and effectively withdrawn in the preliminary position paper. Board Rule 41.2 states that the Board may dismiss a case or an issue on its own motion "if it has a reasonable basis to believe that the issues have been fully settled or abandoned." Indeed, the Board notes that QRS appears to concede that the Provider abandoned the DGME Penalty FTE Count issue because, in its response to the Medicare Contractor's request for dismissal, QRS failed even respond to the Medicare Contractor's contention that the Provider abandoned this issue by failing to brief it in the preliminary position paper.[26] As the Provider abandoned the issue in its preliminary position paper, the Board dismisses the DGME Penalty to FTE Count issue from the appeal.

As a result of this dismissal, no issues remain in the appeal. Accordingly, the Board closes this case 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/25/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

[25] None of the material facts and argument laid out in the March 29, 2024 final position paper were included in the Provider's August 15, 2019 preliminary position paper notwithstanding the requirements in 42 C.F.R. § 405.1853(b)(2), Board Rule 25 and the Board's January 23, 2019 Acknowledgement. Nothing prevented the Provider from raising those arguments then. Had the Provider properly briefed the issue in its preliminary position paper and briefed the challenge to 42 C.F.R. § 413.79(c)(2) as raised in the appeal request, the Board could have considered a potential on-motion EJR.

[26] The fact that the Provider later changed its representative from QRS to K&S has no bearing or relevance to the Board's ruling here as the Provider is responsible for complying with Board rules and regulations.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision- Medicaid Eligible Day***
Northern Louisiana Medical Center (Prov. No. 19-0086)
FYE 09/30/2013
Case No. 17-0497

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Administrative Contractor's ("MAC") Motion to Dismiss. The Board's analysis and determination is set forth below.

Background

A. *Procedural History for Case No. 17-0497*

On November 9, 2016, Northern Louisiana Medical Center filed a request for hearing from a Notice of Program Reimbursement ("NPR") dated May 13, 2016. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)[1]
- Issue 2: DSH Medicaid Eligible Days

On July 26, 2017, the Provider filed its preliminary position paper. As part of this filing, the Provider promised that the Medicaid eligible days listing was "to be emailed separately."[2]

On November 27, 2017, the Medicare Contractor filed its preliminary position paper.

On March 6, 2023, the Board issued a Notice of Hearing and Critical Due Dates scheduling the hearing in the case for December 8, 2023 and requiring the Provider and Medicare Contractor to file their final position papers by September 9, 2023 and October 9, 2023, respectively. The

[1] The Board dismissed this issue on August 22, 2022.
[2] Exhibit C-2 at 16 (copy of Provider's Preliminary Position Paper, Exihibt 1 stating "Eligibility Listing[:] Not included – to be emailed separately").

Notice included the following instructions regarding the content of the Provider's final position paper:

> 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 1 content requirements. If the Provider misses its due date, the Board will dismiss the cases.

On July 24, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid eligible days issue because no listing of Medicaid eligible days was included with the Provider's preliminary position paper and the Provider failed to respond to subsequent requests from the Medicare Contractor to obtain a listing of those days. In this filing, the Medicare Contractor documented that it sent written requests to the Provider's representative that it submit the listing and supporting documentation on the following dates:

- First request sent on December 28, 2018.
- Second request sent on April 3, 2019 as no response was received.
- Third request on March 24, 2023 as no response was received.

Neither the Provider, nor its representative, responded to any of the Medicare Contractor's three (3) discovery requests.[3] Under Board Rule 44.3, the Provider had 30 days to respond to the Medicare Contractor's Motion to Dismiss. Accordingly, the Provider had until Wednesday August 23, 2023 to file its response.

On July 25, 2023, the Provider's designated representative was changed from Community Health Services to Quality Reimbursement Services ("QRS"). In this regard, Board Rule 5.2 makes clear that "the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings."

On August 23, 2023, the deadline to file a response to the Motion to Dismiss lapsed ***without any response from the Provider being filed***. However, *on this same date*, QRS filed the Provider's Final Position Paper and, as part of that filing, included a *preliminary* listing of 212 Medicaid eligible days at issue, "pending finalization upon receipt of State eligibility data." While a response to a Motion needs to be a separate filing, the Board did review the Provider's Final Position Paper for a response; however, it contained ***no reference*** to the Medicare Contractor's Motion to Dismiss and did not discuss its failure to respond to the Medicare Contractor's prior requests to obtain the listing. *Significantly,* ***the listing of 212 Medicaid eligible days is <u>not relevant</u> to the fiscal year at issue (FY 2013)*** *because the listing pertains to patients admitted either during 2017 or 2018*, ***more than 3 years after the fiscal year at issue had closed****.*

[3] The Board notes that 42 C.F.R. § 405.1853(e)(5)(i) instructs that "[e]ach party *is required* ***to make a good faith effort*** to resolve or narrow any discovery dispute, regardless of whether the dispute is with another party or a nonparty"

On September 21, 2023, the Medicare Contractor filed its final position paper.

On November 3, 2023, the Provider filed a Request for Postponement which stated:

> As of November 03, 2023, the Provider is ***unable*** *to submit an additional Medicaid eligible days listing to the MAC due to unforeseen delays at the State Medicaid verification department*. A state eligibility list was previously requested and received but due to a corrupted file format issue, the listing was not useable. A new listing is being request with an approximate timeframe of six weeks.[4]

As a result, the Provider requested a 180-day postponement because it "is finalizing a listing for submission to the MAC but is experiencing a delay in receiving an eligibility listing from the State" and "[t]he next steps are to obtain from the state a Medicaid eligibility report, finalize and submit to the MAC a listing of additional Medicaid eligible days, receive and submit support for the sample, finalize the audit review/adjustments, and draft an administrative resolution." Significantly, the Provider not explain why it had "unforeseen delays", and did not mention the Medicare Contractor's Motion to Dismiss (or claim that its requested postponement served as a belated response to the Motion to Dismiss). Similarly, it did not mention the lisiting attached to its final position paper and how that listing is not relevant to the year at issue (since it pertained to 2017/2018 hospital stays rather than to stays during the FY 2013 at issue in this case). However, the Provider did state that the Medicare Contractor *opposes* the postponement, suggesting that the parties are *not* actively discussing potential resolution.

MAC's Contentions

Issue 2 – DSH – Medicaid Eligible Days

On July 24, 2023, 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 Board's Rules 7, 25.2.1, and 25.2.2 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. § 413.24(c) and §412.106(b)(4)(iii) which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Position Paper affirmative stated that an eligibility listing would be sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in over 4 years since the appeal was filed. The MAC states it contacted the Provider on several occasions: December 28, 2018, April 3, 2019, March 24, 2023, April 24, 2023, and June 16, 2023. Each time the Provider has not responded with an updated list of additional eligible days.

[4] Provider Request for Postponement (Nov. 3, 2023).

Provider's Jurisdictional Response

The Provider did not file a response to the Motion to Dismiss and the 30-day time frame to respond under Board Rule 44.4.3 has lapsed.

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- Medicaid Eligible Days

According to its Appeal Request filed on November 9, 2016, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculations for FY 2013. 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.[5]

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:

[5] Provider's Appeal Request (Nov. 9, 2016)

> 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 Community Health Systems ("CHS") filed the November 9, 2019, appeal request, CHS 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.[6]

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 appeal.

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."14 Board Rule 25 (2018) gives the following instruction on the content of position papers:

[6] (Bold 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.

On July 26, 2017, the Provider filed their preliminary position paper in which it promised that it would be sending the eligibility listing under separate cover.[7]The position paper did not 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.
>
> 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] 2013 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 in the Provider's final position paper and failed to respond to the MAC's subsequent multiple requests to obtain that information from the Provider (as

[7] Provider's Preliminary Position Paper (July 26, 2017).

discussed *supra*). While the Calculation Support filed with their appeal notes a net impact of $22,000, 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. 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 notwithstanding filing formal requests for the listing with supporting documentation on December 28, 2018, April 3, 2019, and March 24, 2023.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.[8]

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 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS 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.)[9] 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"[10]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 preliminary position paper filed on July 26, 2017, that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[11] 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 and notwithstanding the Medicare Contractor's formal requests for that listing filed on December 28, 2018, April 3, 2019, and March 24, 2023. The Provider even failed to respond to the Medicare Contractor's Motion to Dismiss this issue. Indeed, the *belated* listing that the Provider included with its final position paper ***nearly 10 years after FY 2013 ended*** is not relevant as that listing relates to 2017 and 2018 and not FY 2013. Without any days identified in the position paper

[8] 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.
[9] 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.
[10] (Emphasis added.)
[11] Provider Preliminary Position Paper at 10.

filing (or even thereafter), the Board must assume that there are no days in dispute and that the actual amount in dispute 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 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. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[12] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Motion to Dismiss. Accordingly, the Board hereby dismisses the DSH Payment – Medicaid Eligible Days issue.

Decision

The Board hereby dismisses the DSH - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue 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. 17-0497 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:

4/26/2024

X Clayton J. Nix

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

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

[12] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems, Inc.
4000 Meridian Blvd.
Franklin, TN 37067

Michael Redmond
Novitas Solutions, Inc.
c/o GuideWell Source (J-H)
2020 Technology Pkwy., Suite 100
Mechanicsburg, PA 17050

RE: ***Board Decision– SSI Percentage (Provider Specific)***
Sparks Regional Medical Center (Provider Number 04-0055)
FYE: 09/30/2015
Case Number: 20-1280

Dear Messrs. Summar and Redmond,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in the above referenced appeal. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 20-1280

On September 6, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On February 7, 2020, the Provider's representative, Mr. Summar at Community Health Systems ("CHS"), filed the Provider's appeal request with the Board appealing the following nine (9) issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage
- Issue 3: DSH- SSI Fraction/Medicare Managed Care Part C Days
- Issue 4: DSH- SSI Fraction/Dual Eligible Days
- Issue 5: DSH- Medicaid Eligible Days
- Issue 6: DSH- Medicaid Fraction/Medicare Managed Care Part C Days
- Issue 7: DSH- Medicaid Fraction/Dual Eligible Days
- Issue 8: 2 Midnight Census IPPS Payment Reduction
- Issue 9: Uncompensated Care Distribution Pool

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), on September 22, 2020, the Provider transferred Issues 2,3,4, 6, 7 and 8 to Community Health group appeals. Issues 5

and 9 were withdrawn from the appeal by the Provider. The remaining issue in this appeal is Issue 1, DSH SSI Percentage (Provider Specific).

On February 15, 2024, CHS filed the Provider's Final Position Paper.

On March 15, 2024, the Medicare Contractor filed a Jurisdictional Challenge over Issues 1 and 5 requesting that they be dismissed[1]. Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30-day period specified in Board Rule 44.4.3.

On March 18, 2024, the Medicare Contractor filed its Final Position Paper.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation
>
> . . .
>
> The Provider 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.[2]

On September 22, 2020, the Provider was directly added to PRRB Case No. 18-0588GC, appealing from the same NPR as the instant appeal. This common issue related party ("CIRP") group issue statement reads, in part:

> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute.

[1] Issue #5 was withdrawn by the Provider on April 17, 2024.
[2] Provider's Request for Hearing, Issue Statement (Feb. 7, 2020)

. . .

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

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

On February 15, 2024, the Provider filed its final 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 the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.

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

[3] See Issue Statement, PRRB Case No. 18-0588GC.

> Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).

The original appeal request identified the amount in controversy for both Issue #1 and Issue #2 as $99,000. This same amount is listed as the amount in controversy for this Provider as a participant in Group Case No. 18-0588GC.

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH Payment/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.[4]

In addition, the MAC argues that the Provider has abandoned the realignment aspect of the issue by failing to brief it in the preliminary position paper.[5] Finally, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI (Systemic Errors) issue are considered the same issue by the Board, and the Provider is appealing this issue in PRRB Case No. 18-0588GC. The MAC requests the Board to dismiss the SSI data accuracy sub-issue as a duplicate filing in violation of Board Rule 4.6.1.[6]

Provider's Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure

[4] Jurisdictional Challenge at 7 (March 15, 2024).
[5] *Id.* at 6.
[6] *Id*. at 4-6.
[7] Board Rule 44.3, v. 2.0 (Aug. 2018).

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 Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/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 transferred into Group Case No 18-0588GC.

The DSH Payment/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."[8] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] 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."[10]

The Provider's DSH Payment/SSI (Systemic Errors) issue in group Case No. 18-0588GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI (Systemic Errors) issue in Case No. 18-0588GC. Because the issue is duplicative, and duplicative issues appealed from the same

[8] Issue Statement at 1.
[9] *Id.*
[10] *Id.*

final determination are prohibited by PRRB Rule 4.5[11], the Board dismisses this aspect of the DSH Payment/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, the Provider is pursuing that issue as part of the group under Case 18-0588GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in Baystate, may impact the SSI percentage for each provider differently.[12] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 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. For example, the Provider asserts that "the SSI entitlement of individuals can be ascertained from State records"[13] but fails to explain what that means, what the basis for this alleged fact is,[14] or why it is even relevant to the issue. 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 their opponent's positions." Here, it is clear that the Provider failed to fully develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include all exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2(B) (2015) to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2(B) (2015) specifies:

> 25.2 (B) Unavailable and Omitted Preliminary Documents: If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

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,

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[11] PRRB Rules v. 1.3 (July 2015).
[12] The types of systemic errors documented in Baystate did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co., PRRB Dec. No. 2006-D20 (Mar. 17, 2006). See also Baystate Med. Ctr. v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).
[13] Provider's Preliminary Position Paper at 4 (September 30, 2020).
[14] There are no exhibits or citations or examples of how SSI entitlement can be ascertained from state records.

> [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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-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."

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.

Accordingly, based on the record before it, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0588GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

[15] Last accessed April 26, 2024.

2. Second Aspect of Issue 1

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

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal. Further, the Provider abandoned this aspect of the issue by failing to brief it in its Preliminary Position Paper.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (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.

As no issues remain pending, the Board hereby closes Case No. 20-1280 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/26/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

April 26, 2024

Daniel Simmons
Senior Vice President/Treasurer
Monongahela Valley Hospital
1163 Country Club Road
Monongahela, PA 15063-1095

Michael Redmond
Manager, JH & JL Provider Audit & Reimbursement
Novitas Solutions, Inc. c/o GuideWell Source (J-L)
2020 Technology Parkway, Suite 100
Mechanicsburg, PA 17050

RE: Dismissal for Failure to Respond and Failure to Appear
Monongahela Valley Hospital
Provider Number: 39-0147
Appealed Period: FYE 06/30/2016
PRRB Case Number: 19-0978

Dear Mr. Simmons and Mr. Redmond:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a Provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

On September 8, 2023, a Notice of Hearing was issued and established critical due dates and set forth a live hearing date for April 26, 2024. Emails to the Provider representative inquiring about a status on this case have been returned as undeliverable.

Board Rule 41.2 states:

The Board may dismiss a case or an issue on its 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 or filing deadlines (see 42 C.F.R. § 405.1868);
• if the Board is unable to contact the provider or representative at the last known address; or
• upon failure to appear for a scheduled hearing.

As the Provider failed to show for the April 26, 2024 hearing, the Board hereby dismisses this case.

Board Members Participating:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

FOR THE BOARD:

Kevin D. Smith, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Daniel Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue NW, Suite 900
Washington, DC 20006

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

RE: ***Dismissal Decision***
St. Luke's Hospital of Kansas City, Prov. No. 26-0138, FYE 12/31/2014
Case No. 19-0550

Dear Messrs. Hettich and Lamprecht:

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

Background

A. General Procedural History in Case No. 19-0550

On December 21, 2018, the Provider's then-designated representative, Quality Reimbursement Services, Inc. submitted the Provider's request for hearing based on a Notice of Program Reimbursement ("NPR") dated June 28, 2018. The Provider's appeal request included the following issues:

1. DSH SSI Provider Specific
2. DSH Medicaid Eligible Days
3. Direct Graduate Medical Education ("DGME") Penalty to FTE Count
4. DSH SSI Percentage[1]
5. DSH SSI Fraction Medicare Managed Care Part C Days[2]
6. DSH SSI Fraction Dual Eligible Days[3]

[1] Issue 4 was transferred to Case No. 19-0554GC. But as the CIRP Group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 20-1509G.
[2] Issue 5 was transferred to Case No. 19-0555GC. But as the CIRP Group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 20-1510G.
[3] Issue 6 was transferred to Case No. 19-0556GC. But as the CIRP Group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 20-1511G.

7. DSH Medicaid Fraction Medicare Managed Care Part C Days[4]
8. DSH Medicaid Fraction Dual Eligible Days[5]
9. IPPS Understated Standardized Payment Amount[6]

On January 14, 2019, the Board acknowledged the appeal and set deadlines for the parties' preliminary position papers. This notice also gave the following instructions regarding the content of the provider's preliminary position paper:

> Provider's Preliminary Position Paper – ***For <u>each</u> issue,*** *the position paper* ***<u>must</u>*** *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.[7]

On August 15, 2019, QRS timely filed the Provider's preliminary position paper.

On November 5, 2019, the Medicare Contractor filed a Jurisdictional Challenge requesting that the Board dismiss Issue 3. On December 5, 2019, QRS timely filed its response to the Jurisdictional Challenge.

On December 12, 2019, the Medicare Contractor filed its preliminary position paper.

On December 17, 2019, QRS transferred Issues 4 to 9 (*i.e.,* six issues) from this appeal to various single participant CIRP groups for St. Luke's Health. However, between December 18, 2019 and April 1, 2020, these issues ultimately ended up in optional groups as the CIRP groups were fully formed with only one participant.[8]

On February 8, 2023, QRS withdrew Issues 1[9] and 2, *leaving Issue 3 as the* ***sole remaining issue.***

---

[4] Issue 7 was transferred to Case No. 19-0558GC. But as the CIRP Group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 20-1512G.
[5] Issue 8 was transferred to Case No. 19-0559GC. But as the CIRP Group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 20-1513G.
[6] Issue 9 was transferred to Case No. 19-0560GC. But as the CIRP Group was later fully formed with only one participant, the issue was transferred back to the individual appeal. QRS then later transferred the issue to the *optional* group under Case No. 19-0721G.
[7] (Emphasis added).
[8] *See supra* notes 1-6.
[9] On March 5, 2019, the Medicare Contractor filed a jurisdictional challenge over Issue 1 in the appeal. On March 29, 2019, QRS filed a jurisdictional response. That challenge is not moot as the Provider withdrew Issue 1.

On March 7, 2023, the Provider's designated representative was changed from QRS to King & Spalding, LLP ("K&S").

On October 11, 2023, the Board issued the Notice of Hearing setting the June 27, 2024 hearing date and setting deadlines for the parties' final position papers. The Notice included the following instructions regarding the content of the Provider's final position paper:

> Provider's Final Position Paper – ***For <u>each</u> remaining issue,*** the position paper **<u>must</u> 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. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the case.[10]

On March 29, 2024, K&S filed the Provider's final position paper. Similarly, on April 15, 2024, the Medicare Contractor filed its final position paper.

B. Procedural History for Issue 3 – the Sole Remaining Issue in Case No. 19-0550

In its December 21, 2018 appeal request the Provider described Issue 3 as follows:

> **<u>Statement of the Issue</u>**
>
> Whether the Medicare Administrative Contractor ("MAC") must correct its determination of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").
>
> **<u>Statement of the Legal Basis</u>**
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP. 42 U.S.C. § 1395ww(h)(4)(C). CMS's implementation of the cap and weighting factors is contrary to the statute because it imposes on the Provider a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Provider from claiming

[10] (Footnote omitted, italics emphasis in original, and bold and underline emphasis added).

> FTES up to its full FTE cap. See 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payments consistent with the statute so that the DGME cap is set at the number of FTE residents that the Provider trained in its most recent cost reporting period ending on or before December 31, 1996, and the residents beyond the IRP are weighted at no more than 0.5. The Provider self-disallowed this item because the Provider challenges the regulation at 42 C.F.R. § 413.79(c)(2), and the MAC is bound by that regulation.

On August 15, 2019, the Provider filed a Preliminary Position Paper.

On November 5, 2019, the Medicare Contractor filed a Jurisdictional Challenge requesting that the Board dismiss Issue 3. On December 5, 2019, QRS timely filed its response to the Jurisdictional Challenge.

On December 5, 2019, QRS timely filed the Provider's response to the Jurisdictional Challenge.

On March 29, 2024, K&S (*as the newly-appointed representative replacing* QRS) filed the Provider's final position paper. Significantly, the Provider's final position paper only briefs the GME FTE count issue challenging the treatment of fellows in the reimbursement formula at 42 C.F.R. § 413.79(c)(2)(iii) as it relates to the FTE counts for the Provider's present, prior and penultimate years as used in the NPR at issue. Further, the Provider's final position paper does not discuss or acknowledge the open request for dismissal of Issue 3.

Medicare Contractor's Jurisdictional Challenge filed on November 5, 2019

First, the Medicare Contractor asserts that the Provider has improperly expanded Issue 3 (the GME FTE issue) through its Preliminary Position Paper. The Medicare Contractor explains that the Provider described the GME FTE issue in the appeal request as follows:

> Whether the Medicare Administrative Contractor ("MAC") must correct its determination of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").

The Provider objected to the requirement to apply a 0.5 weighting factor to Graduate Medical Education (GME) full time equivalent (FTE) counts, applicable to residents training beyond the initial residency program. However, the Medicare Contractor maintains that the Provider's

appeal request did not mention indirect medical education (IME) FTE counts or the Provider's GME per resident amount (PRA).[11]

The Medicare Contractor goes on to explain that the Provider described the issue as follows in its preliminary position paper:

> The provider contends that the MAC failed to apply the correct full time equivalent ("FTE") resident count in determining the GME and the indirect medical education adjustment ("IME"). Additionally, the MAC failed to apply the correct average per resident amount ("APRA") in determining the direct graduate medical education payment ("GME").[12]

The Medicare Contractor then notes that the Provider states its position with respect to the FTE Count and APRA as follows:

> The Provider will demonstrate in its hearing before the Board that the FTE count applied by the MAC is inappropriate…The Provider will demonstrate in its hearing before the Board that the MAC did not compute the APRA as required by applicable law.[13]

The Medicare Contractor contends that the additional portions of Issue 3, concerning the IME FTE counts and the Per Resident Amount (PRA) were not specifically discussed in the Provider's Request for Hearing. Accordingly, the Medicare Contractor asserts that the Provider must not be permitted to add the issues of IME FTE counts and the PRA to the appeal by simply presenting the issues in its preliminary position paper. The Provider failed to address the issues in their appeal request. In addition, the Provider did not add the issues in the time frame allowed. Thus, the Provider did not comply with 42 C.F.R. § 405.1835(a-e) and Board Rule 6.2.1.[14]

Finally, the Medicare Contractor contends that the Provider has abandoned Issue 3 as it was originally appealed, i.e., the weighting of residents training beyond the IRP because the Provider failed to brief the DGME Penalty to FTE Count portion of Issue 3. The Board Rule at 25.1 requires providers' position papers to include various elements. In accordance with Board Rule 25.1.1(B) a provider must for each issue that has not been resolved, state the material facts that support the provider's claim. Furthermore, Board Rule 41.2 states that the Board may dismiss a case or an issue it has a reasonable basis to believe has been abandoned. Inasmuch as the Provider did not present any argument in support of their position, the Medicare Contractor maintains that the Board should dismiss the DGME Penalty to FTE Count portion of Issue 3.[15]

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[11] Medicare Contractor's Jurisdictional Challenge at 4.
[12] Medicare Contractor's Jurisdictional Challenge at 5.
[13] Medicare Contractor's Jurisdictional Challenge at 5.
[14] Medicare Contractor's Jurisdictional Challenge at 5.
[15] Medicare Contractor's Jurisdictional Challenge at 5.

Provider's Jurisdictional Response filed on December 5, 2019

In its jurisdictional response, QRS states that the issue language in the Provider's individual appeal for direct graduate medical education covers both GME/IME and how it affects the FTE count in broad language and includes the IME FTE and PRA components of the issue.[16]

QRS then inexplicably dives into a long discussion of the DSH payment and the presentment requirement.[17] *Significantly, QRS did **not** address the Medicare Contractor's contention that it abandoned the original DGME issue*. Indeed, it does not discuss the weighting of residents training beyond the IRP much less its original challenge to 42 C.F.R. § 413.79(c)(2).

Board's Decision

The Medicare Contractor has requested that the Board dismiss the IME FTE counts and the Per Resident Amount aspects of Issue 3 that QRS raised in the Provider's preliminary position paper. However, the Medicare Contractor's request is now moot because the Provider abandoned these aspects of Issue 3 (to the extent these aspects of Issue 3 were ever part of this appeal) since the Provider's final position paper (as filed by K&S) does not brief the merits of these aspects of Issue 3. 42 C.F.R. § 405.1853(b)(2) requires position papers to address the merits of each issue in an appeal. To this end, Board Rule 25.3 (Nov. 2021) specifies that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Accordingly, consistent with this regulation and Board Rule 25, the Board finds that the IME FTE count and PRA aspects of Issue 3 were effectively withdrawn from this appeal.

Regardless, to the extent these aspects had not been abandoned in the final position paper, the Board would have dismissed these aspects of Issue 3 consistent with 42 C.F.R. §§ 405.1835(b) and 405.1835(e) (Oct. 2018) because the Provider did not properly include the issue in the original appeal request and timely appeal the issues.

In order for an issue to be part of an appeal request, the request must comply with the content requirements for requesting a Board hearing in an initial appeal.[18] Specifically, 42 C.F.R. § 405.1835(b)(2) (Oct. 2018) requires the following content be included in the appeal request:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and **the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section**. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, **the Board may**

[16] Provider's Jurisdictional Response at 1.
[17] Provider's Jurisdictional Response at 1-7.
[18] 42 C.F.R. § 405.1835(e).

> **dismiss with prejudice the appeal** or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) For each specific item under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in §413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section. [19]

Significantly, the regulation confirms that failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[20]

The Board Rules reiterate the same requirements at Board Rule 7.2.1 by giving the following "General Information" on the content of an appeal request:

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[19] (emphasis added).
[20] 42 C.F.R. § 405.1835(b).

> The following information and supporting documentation must be submitted for each issue raised in the appeal request.
>
> - An issue title and a concise issue statement describing:
>
> - the adjustment, including the adjustment number,
> - the controlling authority,
> - why the adjustment is incorrect,
> - how the payment should be determined differently,
> - the reimbursement effect, and
> - The basis for jurisdiction before the PRRB.
> - A copy of the applicable audit adjustment report page(s) or a statement addressing why an adjustment report is not applicable or available.
> - A calculation or other support for the reimbursement effect noted in the issue statement.
> - Support for protested items or claims of dissatisfaction as noted in Rules 7.3 and 7.4.[21]

Additional guidance is located in Board Rule 8 on "Framing Issues for Adjustments Involving Multiple Components" such as GME:

> **8.1 General**
>
> General Some issues may have multiple components. To comply with the *regulatory requirement to specifically identify* the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. Several examples are identified below, but these are not exhaustive lists of categories or issues.
>
> ****
>
> **C. Graduate Medical Education/Indirect Medical Education**
>
> Common *examples* include: managed care days, new programs, current year resident count, prior year count, penultimate year count, intern to bed ratio, and rotations to non-hospital settings.[22]

[21] PRRB Rule 7.2.1 (Aug. 2018).
[22] (Italics and underline emphasis added and bolded in original).

Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[23] 42 C.F.R. § 405.1835(e) provides in relevant part:

> (c) *Adding issues to the hearing request*. After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if --
>
> ****
>
> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) or paragraph (c)(2) of this section.

In practice this means that new issues had to be added to St. Luke's appeal no later than 240 days after receipt of the Medicare Contractor's determination. In the instant case the deadline to add issues was February 23, 2019. St. Luke's first mention of the understated indirect medical education (IME) full-time equivalent (FTE) counts and Per Resident Amount issues in this appeal was in its preliminary position paper submitted on August 15, 2019, well after the deadline to add issues to the appeal.

Here, the Provider's appeal request does not discuss either IME or the Per Resident Amount issues (and to this end, the amount in controversy calculation does not specifically address these issues). Further, it made no filing subsequent to the appeal request within the time allotted under 42 C.F.R. § 405.1835(e) to add these issues. Accordingly, because the Provider did not raise the understated IME FTE counts and Per Resident Amount issues in its initial appeal request or add the issues to its appeal before the regulatory deadline, the Board finds that these issues were not timely appealed. Therefore, the Board would dismiss these aspects of Issue 3 if the Provider had not already abandoned these issues in its final position paper.

With respect to the original aspect of Issue 3, DGME Penalty to FTE Count issue, the Provider's appeal request challenges the Medicare Contractor's determination of the Provider's cap of FTE residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education. The Medicare Contractor requested that the Board dismiss the original aspect of Issue 3 because the Provider abandoned the issue by failing to brief it in its preliminary position paper.

In reviewing the Provider's preliminary position paper filed by QRS on August 15, 2019, the Board finds that the Provider failed to brief the original aspect of Issue 3 relating to the weighting of residents training beyond the IRP and the associated challenge to the regulation at 42 C.F.R. § 413.79(c)(2). In this regard, the Board notes that the preliminary position paper does not present any arguments regarding the weighting of residents, much less discuss or mention any challenge to § 413.79(c)(2). *In particular, the Provider's preliminary position paper does not address* ***any*** *of the arguments it makes in its final position paper*.

[23] *See* 73 Fed. Reg. 30190 (May 23, 2008).

Board Rule 25 (Aug. 29, 2018) addresses Preliminary Position Papers:

> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will issue a notice setting deadlines for the first position paper generally at eight months after filing the appeal request for the provider, and twelve months for the Medicare contractor. Even though it will not be addressed in the Board's notice the provider may file an *optional* response no later than ninety days following the due date for the Medicare contractor's preliminary position paper. Therefore, the Board requires preliminary position papers to present the ***fully*** developed positions of the parties and expects that parties will be diligent in planning and conducting any required investigation, discovery, and analysis well in advance of the filing deadline.
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must contain the elements addressed in the applicable sub-section.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, provide a ***fully*** developed narrative that:
>
> - States the material facts that support the provider's claim.
> - Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
> - Provides a conclusion applying the material facts to the controlling authorities.
>
> C. Comply with Rule 25.2 addressing Exhibits.

Consistent with Board Rule 25, the Board's Acknowledgement setting the Provider's deadline for filing its preliminary position paper also includes instructions for the content of the Provider's preliminary position paper "[f]or each remaining issue" (as quoted *supra*).

Board Rule **25.3 Filing Requirements to Board** states that if the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn. The commentary to the rule states the following:

> Note that the change to require filing of the ***complete*** preliminary position paper was effective on August 29, 2018. Accordingly, failure to file a ***complete*** preliminary position paper with the Board will result in the Board dismissing your appeal or taking other actions in accordance with 42 C.F.R. § 405.1868.[24]

Moreover, 42 C.F.R. § 405.1868 provides, in pertinent part:

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

The Board dismisses the DGME Penalty to FTE Count issue from the appeal as the Provider did not provide a fully developed narrative that states the material facts that support the Provider's claim, identifies the controlling authorities that support the Provider's position or provide a conclusion that applies the material facts to the controlling authorities.[25] Consistent with 42 C.F.R. § 405.1835(b)(2) and Board Rule 25.3, the Board considers the unbriefed issue

[24] Similarly, the Commentary to Board Rule 23.3 states "CAUTION: New arguments and documents not included in the preliminary position 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)."

[25] None of the material facts and argument laid out in the March 29, 2024 final position paper were included in the Provider's August 15, 2019 preliminary position paper notwithstanding the requirements in 42 C.F.R. § 405.1853(b)(2), Board Rule 25 and the Board's January 14, 2019 Acknowledgment. Noting prevented the Provider from raising those arguments then. Had the Provider properly briefed the issue in its preliminary position paper and briefed the challenge to 42 C.F.R. § 413.79(c)(2) as raised in the appeal request, the Board could have considered an own motion EJR.

abandoned and effectively withdrawn in the preliminary position paper. Board Rule 41.2 states that the Board may dismiss a case or an issue on its own motion "if it has a reasonable basis to believe that the issues have been fully settled or abandoned." Indeed, the Board notes that QRS appears to concede that the Provider abandoned the DGME Penalty to FTE Count issue because, in its response to the Medicare Contractor's request for dismissal, QRS failed even to respond to the Medicare Contractor's contention that the Provider abandoned this issue by failing to brief it in the preliminary position paper.[26] As the Provider abandoned the issue in its preliminary position paper, the Board dismisses the DGEM Penalty to FTE Count issue from the appeal.

As a result of this dismissal, no issues remain in the appeal. Accordingly, the Board closes this case 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/26/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

[26] The fact that the Provider later changed its representative from QRS to K&S has no bearing or relevance to the Board's ruling here as the Provider is responsible for complying with the Board's rules and regulations.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Blvd
Franklin, TN 37067

RE: ***Notice of Dismissal***
Grandview Medical Center (Provider Number 01-0104)
FYE: 06/30/2014
Case Number: 20-0866

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0866. Set forth below is the decision of the Board to dismiss the last remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 20-0866*

On **January 24, 2020**, the Board received Provider's Individual Appeal Request appealing their August 8, 2019 Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 2014. The initial appeal contained the following five (5) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 19, 2020**, the Provider transferred Issues 2 and 5 to CHS CIRP groups. Issues 2 and 3 were also withdrawn on **April 10, 2024** and **August 12, 2020**, respectively.

[1] This issue was transferred to Case No. 18-0109GC on August 19, 2020.
[2] This issue was withdrawn on April 10, 2024.
[3] This issue was withdrawn on August 12, 2020.
[4] This issue was transferred to Case No. 18-0112GC on August 19, 2020.

As a result of the case transfers and withdrawals, there is one (1) remaining issue in this appeal: Issue 1 (DSH – SSI Percentage Provider Specific).

On **January 31, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> 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.[5]

On **September 15, 2020**, the Provider timely filed its preliminary position paper. On **January 8, 2021**, the Medicare Contractor filed its preliminary position paper.

On **December 29, 2021**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issue 1 requesting that the Board dismiss this issue. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

The Provider and Medicare Contractor also filed Final Position Papers on **January 9, 2024** and **February 29, 2024**, respectively.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0109GC - QRS CHS 2014 DSH SSI Percentage CIRP Group

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

---

[5] (Emphasis added.)

[6] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[7]

The Group Issue Statement in Case No. 18-0109GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance

[7] Individual Appeal Request, Issue 1.

with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.

The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

1. Availability of MEDPAR and SSA Records
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible Days, and
6. Covered days vs. Total days[8]

On **September 15, 2020**, the Board received the Provider's preliminary position paper in Case No. 20-0866. 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

[8] PRRB Case 18-0109GC, Group Issue Statement.

> all patients that were entitled to SSI benefits in the Provider's DSH calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $60,000.

On **January 9, 2024**, the Board received the Provider's Final Position Paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI

[9] Provider's Preliminary Position Paper at 8-9 (Sept. 15, 2020).

> percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

MAC's Contentions

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

In its December 29, 2021 Jurisdictional Challenge, the MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for several reasons. First, the MAC argues that the appeal is duplicative:

> According to the Provider's appeal request, Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The MAC contends that the portions of Issue 1 related to SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Group Case No. 18-0109GC, "QRS CHS 2014 DSH SSI Percentage CIRP Group" and should be dismissed.
>
> With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:
>
> > The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
> >
> > The Provider contends that its' [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.

[10] Provider's Final Position Paper at 8-9 (Jan. 9, 2024).

> The Provider contends that the SSI percentage is flawed.

With respect to the portion of Issue 1 related to individuals who are eligible for SSI but did not receive SSI payment, the Provider states:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

This component of Issue 1 is repeated by the Provider, word-for-word, within Issue 2.

The MAC contends that the Provider raises the same disputes in Issue 2. The Provider describes Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as

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

Within Issue 1 and Issue 2, the Provider is disputing the accuracy of its SSI percentage as well as CMS's policy concerning individuals who are eligible for SSI but did not receive SSI payment.

As previously noted, Issue 2 has been transferred to Group Case No. 18-0109GC. This means that the Provider is appealing an issue from a single final determination in more than one appeal. The Board's Rules are clear on this matter: No duplicate filings. Board Rule 4.6.1, states:

> A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).

Consistent with the Board's previous jurisdictional decisions the MAC respectfully requests the Board dismiss the portion of Issue 1 concerning SSI data accuracy.[11]

[11] Medicare Contractor's Jurisdictional Challenge at 4-6 (Dec. 29, 2021).

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> 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 the 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.[12]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[13] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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.

As set forth below, the Board hereby ***dismisses*** the Provider's one (1) remaining issue.

A. DSH Payment/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

[12] *Id.* at 7.
[13] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

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 Case No. 18-0109GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[14] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues in its issue statement, which was included in the appeal request, that 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."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0109GC 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 that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0866 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0109GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

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[14] Issue Statement at 1.
[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 2.0 (Aug. 2018).
[18] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

To this end, the Board also reviewed the Provider's Preliminary Position Paper and Final Position Paper to see if they further clarified Issue 1. However, they failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0109GC, but instead referred to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, they alleged that "SSI entitlement of individuals can be ascertained from State records" but failed to explain how that can be ascertained, to explain how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2.[19] Moreover, the Board finds that the Provider's Preliminary and Final Position Papers failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" 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 (Aug. 29, 2018)**
>
> 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.[20]

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***

[19] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.
[20] (Italics and underline emphasis added.)

> ***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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [21]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[22]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0109GC.

Accordingly, *based on the record before it*,[23] the Board finds that the SSI Provider Specific issue in Case No. 20-0866 and the group issue from the CHS CIRP group under Case No. 18-0109GC 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 Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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[21] Last accessed April 26, 2024.
[22] Emphasis added.
[23] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

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

* * * * *

Based on the foregoing, the Board has dismissed the last remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 20-0866 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/26/2024

X Kevin D. Smith, CPA

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

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Boulevard
Franklin, TN 37067

RE: ***Notice of Dismissal***
Grandview Medical Center (Provider Number 01-0104)
FYE: 06/30/2015
Case No. 20-0869

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request in Case No. 20-0869. Set forth below is the decision of the Board to dismiss the last remaining issue in this appeal challenging the Provider's Disproportionate Share Hospital ("DSH") for SSI Percentage (Provider Specific).

Background

A. *Procedural History for Case No. 20-0869*

On **January 28, 2020**, the Board received Provider's Individual Appeal Request appealing their August 23, 2019 Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 2015. The initial appeal contained the following five (5) issues:

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

As the Provider is commonly owned/controlled by CHS, the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). For that reason, on **August 19, 2020**, the Provider transferred Issues 2 and 5 to CHS CIRP groups. Issues 3 and 4 have also been withdrawn on **April 10, 2024** and **September 15, 2020**, respectively.

[1] This issue was transferred to Case No. 18-0552GC on August 19, 2020.
[2] This issue was withdrawn on April 10, 2024.
[3] This issue was withdrawn on September 15, 2020.
[4] This issue was transferred to Case No. 18-0554GC on August 19, 2020.

As a result of the case transfers, there is one (1) remaining issue in this appeal: Issue 1 (DSH – SSI Percentage - Provider Specific).

On **January 31, 2020**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> 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.[5]

On **September 15, 2020**, the Provider timely filed its preliminary position paper. On **December 7, 2020**, the Medicare Contractor filed its preliminary position paper. The Provider and Medicare Contractor also filed Final Position Papers on **January 9, 2024** and **February 28, 2024**, respectively.

On **April 1, 2024**, the Medicare Contractor timely filed a Jurisdictional Challenge[6] with the Board over Issue 1[7] requesting that the Board dismiss these issues. Pursuant to Board Rule 44.4.3, the Provider had 30 days in which to file a response to the Jurisdictional Challenge. However, the Provider ***failed*** to file any response.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC - QRS CHS 2015 DSH SSI Percentage CIRP Group

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

---

[5] (Emphasis added.)

[6] Jurisdictional Challenges are not limited to jurisdiction *per se* as exemplified by 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

[7] The filing also challenged the Medicaid Eligible Days issue, which has since been withdrawn from the case.

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[8]

The Group issue Statement in Case No. 18-0552GC, to which the Provider transferred Issue No. 2, reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?

[8] Individual Appeal Request, Issue 1.

Statement of the Legal Basis

The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.

The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare statute.

Providers in this case are also seeking resolution of the following aspects of the Medicare fraction that were not addressed in the Baystate case:

1. Availability of MEDPAR and SSA Records
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible Days, and
6. Covered days vs. Total days[9]

On **September 15, 2020**, the Board received the Provider's preliminary position paper in 20-0869. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[9] PRRB Case 18-0552GC, Group Issue Statement.

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 based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services,* No. CV-94-0055 (C.D. Cal June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the completed 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).[10]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $60,000.

On **January 9, 2024**, the Board received the Provider's Final Position Paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made

[10] Provider's Preliminary Position Paper at 8-9 (Sept. 15, 2020).

> available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Center, et al, v Xavier Becerra* (Appellants' reply brief included as Exhibit P-3).[11]

MAC's Contentions

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

In its April 1, 2024 Jurisdictional Challenge, the MAC argues that the Board should dismiss the DSH – SSI Percentage (Provider Specific) issue for several reasons. First, the MAC argues that the appeal is duplicative:

> According to the Provider's appeal request, Issue 1 . . . has 3 sub-components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment.
>
> . . .
>
> With respect to the portion of Issue 1 related to SSI data accuracy, the Provider states:
>
> > The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
> >
> > The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

[11] Provider's Final Position Paper at 8-9 (Jan. 9, 2024).

> The Provider contends that the SSI percentage is flawed.

With respect to the portion of Issue 1 related to individuals who are eligible for SSI but did not receive SSI payment, the Provider states:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

This component of Issue 1 is repeated by the Provider within Issue 2.

The MAC contends that the Provider makes the same disputes in Issue 2. The Provider describes Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as

> Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> Providers in this case are also seeking resolution of the following aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days

Within Issue 1 and Issue 2, the Provider is disputing the accuracy of its SSI percentage as well as CMS's policy concerning individuals who are eligible for SSI but did not receive SSI payment.

As previously noted, Issue 2 has been transferred to Group Case No. 18-0552GC, "QRS CHS 2015 DSH SSI Percentage CIRP Group". Therefore, the Provider is appealing issues from a single final determination in more than one appeal.

The Board's Rules are clear on this matter: No duplicate filings are permitted. In accordance with PRRB Rule 4.6.1, "[a] provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group)."

Consistent with the Board's previous jurisdictional decisions, the MAC respectfully requests the Board dismiss the portion of Issue 1

> concerning individuals who are eligible for SSI but did not receive SSI payment.[12]

The MAC also argues that the subsidiary appeal over SSI realignment has been abandoned because it was not briefed in its Final Position Paper.[13]

The MAC also argues that the appeal is premature because the Provider has not requested realignment in accordance with 42 C.F.R. § 412.106(b)(3):

> 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 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.[14]

Finally, the MAC asserts that the Provider failed to file a complete final position paper for the SSI Data Accuracy issue:

> Notably, the Provider has not added any specific allegations, analysis or information related to the Baystate Errors/DSH SSI Percentage Calculation Accuracy issue that would satisfy the requirements set forth in Board Rules 25.1.1 or 25.2.2. The Provider has essentially abandoned the issue by failing to properly develop its arguments, to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules. Therefore, the MAC respectfully requests that the Board dismiss the issue related to Baystate Errors/DSH SSI Percentage Calculation Accuracy.[15]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider has not

[12] Medicare Contractor's Jurisdictional Challenge at 4-6 (April 1, 2024).
[13] *Id.* at 7.
[14] *Id.* at 7-8.
[15] *Id.* at 10-11.
[16] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. A provider's failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Decision of the Board

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.

As set forth below, the Board hereby ***dismisses*** the Provider's one (1) remaining issue.

A. DSH Payment/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 Errors) issue that was appealed in Case No. 18-0552GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[17] Per the appeal request, the Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues in its issue statement, which was included in the appeal request, that 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."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage,

[17] Issue Statement at 1.
[18] *Id.*
[19] *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 that the DSH Payment/SSI Percentage (Provider Specific) issue in Case No. 20-0869 is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

The Board has previously noted that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and the Provider has failed to explain how this argument is ***specific to this provider***. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper and Final Position Paper to see if they further clarified Issue 1. However, they failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC, but instead referred to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. For example, they allege that "SSI entitlement of individuals can be ascertained from State records" but fail to explain how it is ascertained, or to explain how that information is relevant, and whether such a review was done for purposes of the year in question, consistent with its obligations under Board Rule 25.2.[22] Moreover, the Board finds that the Provider's Preliminary and Final Position Papers failed to comply with Board Rule 25 (Aug. 29, 2018) governing the content of position papers. As explained in the Commentary to Rule 23.3 (Aug. 29, 2018), the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" 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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[20] PRRB Rules v. 2.0 (Aug. 2018).

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

[22] It is also not clear whether this is a systemic issue for CHS providers in the same state subject to the CIRP rules or something that is provider specific because, if it was a common systemic issue, it was required to be transferred to a CIRP group "no later than the filing of the preliminary position paper" in this case per Board Rule 12.11. The Provider fails to comply with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules to fully brief the merits of its issue.

> **25.2.2 Unavailable and Omitted Documents (Aug. 29, 2018)**
>
> 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.[23]

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [24]

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."[25]

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[23] (Italics and underline emphasis added.)
[24] Last accessed April 26, 2024.
[25] Emphasis added.

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, 80 F.4th 346 (D.C. Cir. 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to or why this is not a common issue already covered by the CIRP group under Case No. 18-0552GC.

Accordingly, *based on the record before it*,[26] the Board finds that the SSI Provider Specific issue in Case No. 20-0869 and the group issue from the CHS CIRP group under Case No. 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

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

Additionally, the Board finds that this aspect of the appealed issue was abandoned when the Provider failed to brief it in its Preliminary Position Paper.

* * * * *

Based on the foregoing, the Board has dismissed the last remaining issue in this case – (Issue 1). As no issues remain, the Board hereby closes Case No. 20-0869 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.

[26] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/26/2024

X Kevin D. Smith, CPA

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

cc: Cecile Huggins, Palmetto GBA (J-J)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Cecile Huggins
Palmetto GBA
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202

RE: ***Board Decision to Dismiss Remaining Issues***
Flowers Hospital (Prov. No. 01-0055)
FYE 9/30/2017
Case No. 22-0785

Dear Mr. Ravindran and Ms. Huggins:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0785, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 22-0785

On **February 14, 2022**, Flowers Hospital ("Flowers" or "Provider"), appealed a Notice of Program Reimbursement (NPR) dated August 20, 2021, for its fiscal year end (FYE) September 30, 2017 cost reporting period. The Provider appealed the following issues:[1]

- Issue 1: Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific);
- Issue 2: DSH/SSI Percentage (Systemic Errors);[2]
- Issue 3: DSH Payment-Medicaid Eligible Days;
- Issue 4: DSH Payment-Medicare Managed Care Part C Days (SSI Fraction & Medicaid Fraction);[3]
- Issue 5: DSH Payment-Dual Eligible Days (SSI Fraction & Medicaid Fraction).[4]

As the Provider is commonly owned by Community Health Systems ("CHS"), the Provider transferred issues 2, 4 and 5 to common issue related party ("CIRP") group appeals for CHS. As

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Feb. 14, 2022).
[2] The Provider transferred this issue to Case No. 20-0997GC on September 8, 2022.
[3] The Provider transferred this issue to Case No. 19-2620GC on September 8, 2022.
[4] The Provider transferred this issue to Case No. 20-1383GC on September 8, 2022.

a result of these transfers, two issues remain pending in the appeal: Issue 1 – SSI (Provider Specific), Issue 3 – Medicaid Eligible Days.

On **February 15, 2022**, the Board issued the Case Acknowledgement and Critical Due Dates Notice setting the due dates for the parties' preliminary position papers. The Notice includes the following content requirements for 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.[5]

On **October 3, 2022**, the Provider timely filed its preliminary position paper. Significantly, with respect to Issue 3 (the Medicaid eligible days issue), the Provider did not identify the days at issue or include a listing of the days at issue but rather promised that they were "being sent under separate cover."

On **November 10, 2022** (after the October 22, 2022 deadline), the Provider filed a corrected copy of the Provider's preliminary position paper. Significantly, with respect to Issue 3 (the Medicaid eligible days issue), the Provider *again* failed to identify the days at issue or include a listing of the days at issue but rather promised that they were "being sent under separate cover."

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

On **January 23, 2023**, the Medicare Contractor filed a Jurisdictional Challenge, requesting dismissal of the 2 remaining issues – Issse 1 (the DSH SSI Percentage (Provider Specific) issue) and Issue 3 (the Medicaid eligible days issue). With respect to Issue 3, the Medicare Contractor alleged the Provider failed to file a complete position paper as it failed to identify the days at issue and include a listing of those specific days consistent with Board Rule 25.

Pursuant to Board Rule 44.3, the Provider had 30 days to file its response to the jurisdictional challenge (i.e., until Wednesday, February 22, 2023). However, the Provider failed to file any response by this deadline.

On February 28, 2023, the Provider changed its designated representative to Quality Reimbursement Services, Inc. ("QRS"). On **March 14, 2023** (*20 days after the deadline*), QRS filed a *belated* response without either acknowledging or explaining why it was being filed late. In this regard, the Board notes that Board Rule 5.2 specifies that "the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings."

[5] (Emphasis added.)

On November 3, 2023, QRS filed a "Supplement to Position Paper/Redacted Medicaid Eligible Days Listing Submission" that attach a spreadsheet of "Additional ME Days." While the filing does not identify the total number of days, the Board calculates the listing to total 2219 days. QRS' filing did not explain why the listing was being filed outside of the filing deadlines specified in the Board's February 15, 2022 Notice of Critical Due Dates. Contrary to its title, the filing is essentially an Exhibit as it does not "supplement" any argument made in the preliminary position paper since there is no narrative in the filing.

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

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

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

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**
>
> **Provider Specific**

[6] Provider's Request for Hearing, Issue Statement (Feb. 14, 2022).

> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(S)(F)(i). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Alabama and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Alabama and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MED PAR") 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.[7]

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 $82,377. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-0997GC, which is a "Systemic Errors" SSI group.

MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

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

The MAC contends that Issue 1 has three components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. It is noted that Issue 2 was transferred into Group Case No. 20-0997GC, *CHS CY 2017 DSH SSI Percentage CIRP Group*.[8] The MAC contends that the first and third sub-issues should be dismissed because they are duplicative of the issue under appeal in Group Case No. 20-0997GC. The MAC relies on PRRB Rule 4.6.1, which prohibits a provider from appealing the same issue from a single determination in more than one appeal.

With respect to SSI realignment, the MAC contends that this issue has been abandoned. They assert that the Provider did not brief the issue of SSI realignment within its preliminary position paper. As a result, it should be considered withdrawn in accordance with Board Rule 25.3. Alternatively, if the Board determines that the issue was not withdrawn, the MAC asserts that the Board does not have jurisdiction over realignment. There was no final determination over the SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.

Lastly, the MAC asserts 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 filed an ***untimely*** response to the jurisdictional challenge on March 14, 2023 and failed to include any explanation for why the response was being filed late.

Regarding the DSH SSI Fraction, the Provider notes that it has not submitted the Supplemental Security Insurance ("SSI") data used by the Centers for Medicare & Medicaid Services ("CMS") for computation of the DSH Medicare Fraction because CMS will not release the SSI data.[9]

Although CMS does make certain SSI data available, the Provider remarks that this data is inadequate and does not provide all patient payment status codes and other necessary information required to fully support this issue. At this time, CMS has not made this additional information available and has provided no process through which the provider could obtain this necessary information.

Regarding the Medicaid Eligible Days issue, Provider argues that while the MAC relies on Board rule 25.3, it is unclear whether the MAC relies on the current Board rules version 3.1 or the Board Rules Version 2.0 (8/29/2018), which was in effect in 2019 when the Preliminary Position Paper was filed. Under Board Rules Version 2.0, a Final Position Paper is required for appeals filed prior to the effective date of Version 2.0. It was the reasonable understanding and

[8] MAC's Jurisdictional Challenge, at 2.
[9] Provider's Jurisdictional Response, at 1 (Mar. 14, 2023).

expectation of the Provider, therefore, that the outside date for submission of the listing of additional Medicaid eligible days was the Final Position Paper deadline.[10]

Just as the operations of the Board and the MAC were disrupted by the COVID pandemic, as witnessed by the issuance of Alert 19, the operations of the Provider likewise were disrupted. Indeed, the Provider faced, and continues to face, the challenge of providing lifesaving health services to patients suffering from COVID (and, more recently, children suffering from life-threatening respiratory disease).

Accordingly, Provider requests that the Board find the Provider has not abandoned the issue and not dismiss the issue for the reasons stated above.[11]

Board Analysis and Decision

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

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The Board finds that the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers.

In making this finding, the Board first 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 the Provider has failed to explain how this argument is ***specific to this provider***, as the issue title asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[12] The Provider 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

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

(or give any examples or provide evidence) in its appeal request of how the alleged "provider specific" errors are specific to this provider.

To this end, the Board has also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[13] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[14]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.[15]

Accordingly, the Board must find that the Provider failed 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 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. Furthermore, the Provider in this appeal is appealing from a September 30 fiscal year end, therefore a request for realignment is illogical.

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

[13] (Last accessed Nov. 21, 2022.)
[14] (Emphasis added.)
[15] In this regard, the Board notes that even if the Board were to consider QRS' untimely response to the Jurisdictional Challenge, it fails to account for the D.C. Circuit's *Advocate Christ* decision and incorrectly suggests that the issue is still being litigated before the D.C. Circuit.

> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[16]

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

On October 3, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (*e.g.*, whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **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

[16] *Id*.
[17] Provider's Preliminary Position Paper, at 8 (Oct. 3, 2022).

> 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.

While the Calculation Support filed with their appeal notes a net impact of $93,658, 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, as the MAC has asserted in its DSH Package Information Request,[18] the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to

[18] MAC's Information Request – DSH Package (Apr. 28, 2021).

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.[19] In this regard, the Board notes that the Provider filed its preliminary position paper on October 3, 2022, ***more than 5 years after the close of the fiscal year at issue***. As such, the Provider had more than ample opportunity to identify the days at issue.[20] Indeed, it is hard to believe that the Provider is seriously pursuing this issue given the passage of that time and its failure to even timely respond to the Medicare Contractor's request to dismiss Issue 3.

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*.[21]

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

---

[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] In this regard, the Board notes that the Secretary stated in the final rule published on November 13, 2015 that generally 17 months after the close of a provider's fiscal year (the filing of the cost report is due the last day of the 5th month after the close of the fiscal year) is sufficient time for the provider to identify any additional Medicaid eligible days missed in the as-filed cost report:

> In our experience, we believe an additional 12 months [after the filing of the cost report on the last day of the 5th month following the end of the fiscal year] is sufficient time for States to make Medicaid eligibility determinations and for hospitals to revise its number of Medicaid-eligible patient days in order to make an appropriate cost report claim for a DSH payment adjustment.

80 Fed. Reg. 70298, 70564 (Nov. 13, 2015).

[21] (Emphasis added.)

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

Similarly, with regard to position papers,[22] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3). This requirement was restated in the Notice giving the deadline for the Provider's preliminary position paper.

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[24]

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

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

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

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

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

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 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)(4)(iv), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [25] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue with its preliminary position paper as required by the controlling regulations and Board Rules. Nor did the Provider provide in its preliminary position paper an explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2 (*i.e.*,I t did not "1. Identify the missing document; 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"). The Provider's failure to document the material facts and supporting documentation in its *perfunctory* preliminary position paper filing (*i.e.*, failed to provide the number of days in dispute and identify the specific days at issue) or explain why it was unable to do so rendered the position paper process specified in the Board February 15, 2022 Notice meaningless and confirmed that there was $0 at issue for Issue 3.

Finally, the Board refuses to accept the November 3, 2023 filing of the *belated* exhibit showing 2219 additional days because: (1) that exhibit was supposed to have been filed with the preliminary position paper per 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv), Board Rule 25, and the Board's February 15, 2022 Notice; and (2) QRS failed to establish good cause as to why that exhibit was being filed late consistent with Board Rule 25.2.2 and, indeed, included no explanation in its November 3, 2023 filing.[26] In this regard, the Board recognizes that QRS' ***untimely*** response to the Medicare Contractor's motion to dismiss Issue 3 raised generic, perfunctory concerns regarding COVID-19. The Board decline to accept QRS' ***late-filed***

[25] (Emphasis added.)
[26] As noted in Board Rule 25.2.1, "With the position papers, the parties must exchange all available documentation as exhibits to fully support your position." Similarly, Board Rule 25.2.2 provides an exception that the Provider here did not meet: "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."

response and further notes that, if this were true, then any such COVID-19 concerns affect the *content* of the preliminary position paper filing should have been included in the preliminary position paper that the Provider filed, consistent with Board Rule 25.2.2.[27]

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iv) and Board Rules 25.2.1 and 25.2.2 (as well as the instructions in the Board's February 15, 2022 Notice) 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.[29]

*****

In summary, as 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.

In so finding, the Board takes administrative notice that it has made similar dismissals in *numerous* other cases involving CHS and numerous other cases in which QRS was the designated representative.[30] Notwithstanding, QRS failed to properly develop the SSI Provider

[27] Board Alert 19 only pertained to *deadlines* and did ***not*** pertain to the *content of any filings*. If the Provider wished to be excused from the content requirements of any filing that it made, then it had a responsibility to make that known to the Board consistent with Board Rule 25.2.2.
[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.
[29] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).
[30] Examples of QRS-represented individual provider cases which the Board dismissed the SSI Provider-Specific issue and/or the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (Medicaid eligible days issue) dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16-2521 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (Medicaid eligible days dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (both issues dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 17, 2018 and Mar. 2, 2022); Case No. 17-1747 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 24, 2018 and Oct.

Specific issue in its appeal request or its preliminary position paper and failed to provide the Medicaid eligible days listing with its preliminary position paper.

As there are no more issues 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/26/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

17, 2022); Case No. 15-2294 (Medicaid eligible days issue dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (both issues dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (both issues dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (both issues dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Mar. 8, 2023).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Leslie Goldsmith, Esq.
Bass, Berry & Sims, PLC
1201 Pennsylvania Ave., NW, Ste. 300
Washington, DC 20004

RE: ***Notice of Dismissal of Part C Appeals Based on June 9, 2023 Final Rule***
Case No. 24-0317G, *et al.* (*see* **Appendix A** listing 5 cases)

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the five (5) above-referenced common issue related party ("CIRP") and optional group cases (4 CIRPS and 1 optional). Set forth below is the decision of the Board to dismiss these five (5) group appeals challenging the Secretary's policy governing treatment of Medicare Part C Days in the disproportionate share hospital ("DSH") adjustment calculation from the final rule published on June 9, 2023 entitled "Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage" (hereinafter the "June 2023 Final Rule").[1]

Background:

Bass, Berry, & Sims, PLC ("Bass Berry") represents a number of Providers in 4 CIRP and 1 optional group cases which are challenging the treatment of Medicare Part C Days in the DSH adjustment calculation as appealed from the June 2023 Final Rule. Between December 1 and December 5, 2023, Bass Berry initiated these appeals by filing appeal requests on behalf of 5 different CIRP and optional groups concerning the June 2023 Final Rule that the Secretary of Health and Human Services ("Secretary") published as it relates to the those providers' Medicare disproportionate share hospital ("DSH") adjustment calculation and attached to these appeal requests a PDF copy of that Final Rule labeled as "Final Determination Document."[2]

In the June 2023 Final Rule, the Secretary adopted and finalized *its policy* to include Part C days in the SSI fraction as used in the DSH adjustment calculation for Part C discharges occurring *prior to* October 1, 2013 and applied this policy *retroactively* to certain open fiscal years to which this policy would appeal (*i.e.,* the retroactive pre-October 1, 2013 application is limited in scope).

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *Id.*

In violation of Board Rule 12.5 and without permission from the Board,[3] each group was formed to pertain to multiple calendar years without relating to reimbursement for FFY 2024[4] (*e.g.*, the participants in Case No. 24-0317G seek certain additional DSH reimbursement for fiscal years ranging from 2004 to 2013). The ***sole*** issue in each of these appeals is "whether Part C days are properly included in the denominator of the Medicare Fraction per a June 9, 2023, *retroactive* final rule issued by the Centers for Medicare & Medicaid Services ("CMS"), which is binding on the Medicare Administrative Contractor ("MAC"), or whether such final rule is illegal and cannot be enforced."[5] Thus, the Providers challenge the procedural and substantive validity of the policy adopted and finalized in the June 2023 Final Rule.[6] To that end, the appeal requests for these 6 groups identify the June 2023 Final Rule as the "final determination" being appealed and also included a PDF copy of that Final Rule with the label "Final Determination Document." *Significantly, **none of the appeals** included a copy of alleged "accompanying SSI ratios—as to the DSH payment amount they will receive for the fiscal years at issue*."[7]

The Providers' appeal requests have not provided ***any*** explanation in their appeal requests of why the Board has jurisdiction over their appeal of the June 2023 Final Rule and *none has specifically demonstrated that the Final Rule is, **in fact, applicable to them***. In this regard, the appeal requests do not include ***any*** *NPR or revised NPR in their appeal requests* (to document their eligibility for a DSH adjustment for the relevant fiscal year) or documentation of any CMS Ruling 1739-R remands from prior appeals of the DSH Part C days issue for the same year. As explained below, it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

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[3] Board Rule 12.5 states:

> A group may cover only one calendar year unless the Board allows the group to be expanded. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, a group may submit a written request to include more than one calendar year if it cannot meet the minimum number of providers or the $50,000 amount in controversy requirements. The request must:
>
> - Identify the additional calendar year(s) desired to be included in the group;
> - Explain why the expansion is needed (e.g., to meet the minimum number of providers and/or to meet the $50,000 amount in controversy requirement); and
> - Address whether there are any issues of fact or changes in legal authority that might result in different decisions across the years covered by the request in order to ensure that, if the Board were to grant the requested expansion, the resulting expanded group would continue to meet the requirements for a group appeal (see Rule 13).
>
> Failure to include the above information in the request will result in denial of the request.

[4] If a federal fiscal year is appealed (e.g., FFY 2024 which runs from October 1, 2023 through September 30, 2024), then it relates to those portion of the provider's fiscal year that occur during the federal fiscal year at issue. For example, if a provider has a fiscal year ending December 31st, then an appeal of FFY 2024 would involve the last quarter of the provider's FY 2023 (*i.e.*, October through December 2023) and the first three quarters of its FY 2024 (*i.e.*, January through September 2024).

[5] Issue Statement at 1 in Case No. 24-0317G (emphasis added). Each of the Issue Statements in the 5 Bass Berry appeals referenced in this decision are materially identical.

[6] 88 Fed. Reg. 37772 (June 9, 2023).

[7] Issue Statement at 1 in Case No. 24-0317G (emphasis added).

Issue in Dispute:

Bass Berry is the group representative for these 5 cases filed between December 1 and December 5, 2023. Each case has the same material issue statement, which states the issue is:

> The issue in this appeal is whether the Final Rule,[8] which retroactively applies a change in policy to include Part C Days in the Medicare Fraction and exclude these days from the Medicaid Fraction, is substantively invalid, procedurally invalid, or both.[9]

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[10] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[11]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[12] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[13]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which

[8] Referencing Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage, 88 Fed. Reg. 37,772 (June 9, 2023).
[9] Issue Statement at 1 in Case No. 24-0317G. Each of the Issue Statements in the 5 Bass Berry appeals referenced in this decision are materially identical.
[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*
[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[17]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[18]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[19]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[20]

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

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[21] stated that:

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[17] (Emphasis added.)
[18] 42 C.F.R. § 412.106(b)(2)-(3).
[19] (Emphasis added.)
[20] 42 C.F.R. § 412.106(b)(4).
[21] of Health and Human Services.

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[22]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[23]

With the creation of Medicare Part C in 1997,[24] 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.[25]

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*

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[22] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[23] *Id.*
[24] 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.
[25] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> *the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[26]

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."[27] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[28]

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.[29] 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).[30] 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, the Secretary 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."[31]

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[26] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[27] 69 Fed. Reg. at 49099.
[28] *Id.* (emphasis added).
[29] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[30] *Id*. at 47411.
[31] 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

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[32] In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[33] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[34] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[35] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[36] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[37] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[38] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[39] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[40] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[41]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[42] On August 17,

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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).

[32] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

[33] 746 F. 3d 1102 (D.C. Cir. 2014).

[34] *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.").

[35] *Id.* at 2011.

[36] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).

[37] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

[38] 139 S. Ct. 1804 (2019).

[39] *Id.* at 1817.

[40] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.

[41] 139 S. Ct at 1814.

[42] 85 Fed. Reg. 47723 (Aug. 6, 2020).

2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (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 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.[43]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[44] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[45]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions

[43] CMS Ruling 1739-R at 1-2.
[44] 88 Fed. Reg. 37772 (June 9, 2023).
[45] *Id.* at 37775 (emphasis added).

> that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[46]

Decision of the Board:

As set forth below, the Board hereby ***dismisses*** the Providers' appeals because: (1) they failed to appeal from a "final determination" as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1)) and ; and (2) *to the extent the June 2023 Final Rule is* ***in fact*** *applicable to them*, their appeals are premature and their appeal requests failed to meet the content requirements for a request for Board hearing as a group appeal.

A. The Part C Policy finalized in the June 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

In filing these group appeals, the Providers identified the June 2023 Final Rule as the "final determination" being appealed and, to that end, attached a PDF copy of that Final Rule labeled as "Final Determination Document." As this is a final rule (as opposed to an NPR or revised NPR), they appear to be asserting that their right to appeal is based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). In this regard, § 1395oo(a) the following in pertinent part:

> **(a) Establishment**
>
> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and* *which has submitted such [cost] reports* *within such time as the Secretary may require* *in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A) . . .
>
> (ii) is dissatisfied with a final determination of the Secretary *as to the amount of the payment* under subsection (b) or (d) of section 1395ww of this title, ...[47]

However, the Board finds that the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, the providers' appeals are premature as described below.

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[46] 88 Fed. Reg. at 37788 (emphasis in original).
[47] (Bold emphasis in original and italics and underline emphasis added.)

Unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[48] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[49]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[50] Examples of other adjustments to IPPS payment rates that are based, in

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[48] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

[49] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*), but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

[50] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
>
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with

whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[51] direct graduate medical education ("GME"),[52] and indirect GME.[53]

Here, none of the Providers' appeal requests included a copy of the NPR or revised NPR (with associated audit adjustment pages) for the year at issue that would underlie the alleged pending remand to the MACs. As a result, it is unclear whether that those NPRs/revised NPRs addressed consistent with 42 C.F.R. § 412.106(i) both: (1) whether each of these Providers is eligible for a DSH payment *for the relevant year at issue*; and (2) if so, how much.[54]

> the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> ****
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[51] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[52] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").

[53] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **final settlement** of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

[54] In this regard, a provider that did not qualify for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in a ***prior*** fiscal year, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in a subsequent fiscal year. For each fiscal year, the Medicare contractor

The four corners of the June 2023 Final Rule confirms that the Providers appeals are premature because the June 2023 Final Rule confirms both that: (1) it is ***not*** a final determination appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue but only for certain *open* cost reporting periods relating to discharges occurring prior to October 1, 2013. It does not make any determination on *any* hospital's DSH eligibility (much less these Providers') and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less these Providers for the relevant years at issue) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal years. Further, the following excerpts from the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports***. *In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[55]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[56]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***.

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determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

[55] 88 Fed. Reg. at 37774-75 (emphasis added).

[56] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

> Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[57]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[58]

The above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be *not* able to ***directly*** appeal from Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of the yet-to-be issued NPRs (original or revised) that: (1) would be issued *following publication of the new SSI percentages*; and (20 would both apply the finalized policy and would be sued to determine DSH eligibility for a hospital's prior pre-October 1, 2013 cost reporting period that is still open for resolution (whether through issuance of an original or revised NPR[59]) and, if so, the amount of the DSH payment. Here, if the June 2023 Final Rule will be applied to them for the fiscal years at issue, then it is clear that Providers' appeals are premature as they will have an opportunity to later file an appeal to challenge the policy at issue once their respective fiscal year NPRs/revised NPRs are issued *consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i)*.

This reading of the final rule is also supported by CMS Ruling 1739-R which similarly contemplated DSH reimbursement being calculated by the relevant Medicare contractor ***after*** issuance/promulgation of the new rule on the treatment of Part C days:

> Pursuant to this Ruling, *CMS and the Medicare contractors will **not** calculate* the SSI fractions, Medicaid fractions, ***or** DSH payment amounts that depend upon them, **necessary** for the DSH payment adjustment for discharges prior to October 1, 2013*, ***until** a new rule is promulgated* through notice and comment rulemaking that addresses the treatment of MA days.[60]

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[57] *Id.* at 37788 (emphasis added).
[58] *Id.* (emphasis added).
[59] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.
[60] CMS Ruling 1739-R at 8 (Aug. 17, 2020) (emphasis added).

The Board recognizes that the Part C issue has a long litigation history and the most recent is referred to as the *Allina II* litigation.[61] However, the *Allina II* litigation has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[62]

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[63] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. *Memorial Hospital* concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the cases at hand where Providers are appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that Final Rule[64]). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C.

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[61] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").

[62] Rather, *Allina II* addresses the Board's "no-authority determination" when it granted EJR for the *Alliana II* providers. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, the Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[63] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the cases at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, (as discussed *infra*) the Providers did *not* appeal the publication of SSI fractions but rather the final rule finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued NPRs/revised NPRs for the hospital covered by the terms of that final rule. To this end, in finalizing that policy in the June 2023 Final Rule, the Secretary announced that "CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

[64] The Providers' appeal requests are clear that they were filed to appeal from the June 2023 Final Rule, as opposed to appeal from any publication of SSI fractions. Indeed, it is not clear from the record before the Board whether any new SSI percentages for these Providers *for the specific fiscal years appealed* have been in fact issued *pursuant to the implementation of the June 2023 Final Rule as set forth therein*. To this end, the Board notes that 42 C.F.R. § 405.1837(c)(3) requires an appeal request to include a copy of the final determination being appealed, but none of the appeal request include a copy of the publication of any SSI fractions.

District Court distinguished this case because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[65] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* it could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[66] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[67]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[68]

This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only*** ***variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[69] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[70]

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[65] 2022 WL 888190 at *8.
[66] *Id.* at *9 (emphasis added).
[67] *Id.* at *8.
[68] *Id.* at *9.
[69] 795 F.2d at 143 (emphasis added).
[70] *Id.* at 147 (footnote omitted).

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was finalized in the June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Providers for their various fiscal years at issue. Rather, the June 2023 Final Rule reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[71] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[72] In this regard, the Board again notes that the June 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new SSI percentages*, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) the hospital's DSH eligibility for relevant period that remains open for resolution (whether for issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[73]

In summary, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a) and the appeal (as alleged) appears premature.[74] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required (as explained in 42 C.F.R. §§ 405.1837(a)(1) and 405.1837(c)(1)) before the Board can exercise jurisdiction over an appeal,[75] and since the Providers have failed to demonstrate in its hearing request that those criteria have been met for the fiscal years under appeal.[76]

B. To the extent the Providers are also attempting to appeal from the alleged publications of SSI Ratios "published on or about October 15, 2023," the Board would similarly dismiss these appeals because the appeal requests are fatally flawed.

To the extent the Providers are also attempting to appeal from the *alleged* publications of SSI Ratios *published at an* ***unspecified*** *date*, the Board would similarly dismiss these appeals because, notwithstanding the requirements in 42 C.F.R. §§ 405.1837(c), the Providers did not properly identify it as a "final determination being appealed nor did they attach a copy of that publication to their appeal request *as specifically required under those regulations*. A vague reference to CMS

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[71] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[72] 2022 WL 888190 at *9 (emphasis added).
[73] *See infra* at Section C of the Decision confirming that none of the Providers properly appealed from the alleged publication of SSI fractions "on or about October 15, 2023."
[74] The Board's dismissal does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass the Providers depending on the nature and status of the alleged remand(s) referenced by the Providers and the issuance of revised NPRs as appropriate and consistent with the terms of that remand.
[75] 42 C.F.R. § 405.1840(a), (b).
[76] 42 C.F.R. § 405.1837(c).

posting the alleged publication on its website does not and cannot satisfy the specific regulatory requirement to attach a copy of the final determination being appealed to the appeal request.[77]

To this end, a copy of the actual determination being appealed is needed to confirm a number of basic jurisdictional requirements. In this respect, it is not clear whether *each* of these Providers were, in fact, included in that alleged publication (much less whether *each Provider's relevant fiscal year* is even open/pending for the DSH SSI Part C issue as discussed in Section C below). Similarly, it is unclear from the appeal requests what years are covered by the *alleged* publication and whether that corresponds to the years under appeal. Finally, the Board notes that the Providers are unsure of the date of the *alleged* publication, and that an *actual* publication date is not documented in the record. As a result, it would be impossible for the Board to determine whether an appeal of the *alleged* publication was timely filed.

Based on the above, it is clear that any Provider claims that they appealed from the *alleged* publication of the SSI rations at issue would be fatally flawed and the Board would exercise its discretion under to dismiss those appeals for failure to comply with the mandatory content requirements for appeal requests located at 42 C.F.R. §§ 405.1837(c).

C. Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that the Final Rule Was, In Fact, Applicable to Them For the Fiscal Years at Issue.

42 C.F.R. § 405.1837(c) specifies the content requirements for a request for a Board hearing as a group appeal. The Providers have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included **any** information related to any relevant NPRs or revised NPRs or any information on any other pending appeal that may have been remanded to the MAC by Court Order and/or CMS Ruling 1739-R*. In this regard, the Board notes that it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination."

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[77] 42 C.F.R. §§ 405.1835(b)(3) and 405.1837(c)(3). The Board recognizes in footnote 3 of the issue statement the representative includes a link to the following website page last accessed on November 13, 2023 alleging that "CMS 1739-F SSI Ratios, [are] available at [that that website]": https://www.cms.gov/medicare/payment/prospective-payment-systems/acuteinpatient-pps/disproportionate-share-hospital-dsh. However, the Providers' representative fails to confirm: (1) that there is an SSI ratio posted there for each Provider relative to each of that Provider's fiscal years at issue (e.g., does the Moses H. Cone Memorial Hospital have an SSI ratio posted there for its FYs 2005, 2006, 2007, 2009, 2010 and 2011, the fiscal years it appeal in Case No. 24-0317G?); and (2) the date that the SSI ratios at issue were published. In this regard, the Board accessed this page on April 26, 2024 and notes that it has a last modified date of "04/10/2024 04:21 PM."

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section."

Here, none of the Providers include as part of their appeal requests any documentation relating to which final contractor or Secretary determination they seek to appeal, notwithstanding their responsibilities under 42 C.F.R. § 405.1837(c) as quoted above.

Without having the NPR or any additional documentation on the Providers' final determination as it relates to the fiscal years at issue, the Board cannot confirm that the June 2023 Final Rule is, *in fact*, applicable to the Provider's for the fiscal years at issue (*i.e*., that the fiscal years appealed by the Providers remain open and are eligible for resolution of the Part C days issue raised in the this appeal *through the operation of the June 2023 Final Rule*). The Group Representative only includes the following obtuse statement in the group issue statement without explaining what it means or providing any documentation to establish it as true for each of the participants: "Providers previously, successfully challenged CMS's unlawful change in policy governing the treatment of Part C Days pre-FFY 2014; because the Final Rule was issued as a remedy for CMS's prior unlawful conduct, this challenge is a continuation of Providers' earlier appeals—including any such interest accruing thereunder."

Similarly, if the Providers' had remand(s) for the DSH SSI Part C issue for the fiscal years at issue and those remands were still pending before MAC, then the Remand Order itself (whether from a Court, the Administrator, or the Board) is relevant since it might otherwise preclude Board consideration of these appeals; however, the Providers failed to submit any documentation with the appeal requests to confirm any such remands.[78] In this regard, the Board is unable to determine whether each of the Providers even qualified for a DSH payment during the fiscal years at issue since the record does not include a copy of the relevant NPR/revised NPR with the relevant audit adjustment pages alleged to have been issued to the Providers for the relevant fiscal years. Accordingly, the Board finds that the Providers' group appeal requests are *fatally* flawed because, even if the June 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is, in fact, applicable *to the fiscal years appealed by the Provider* given their failure to comply with the content requirements of 42 C.F.R. § 405.1837(c) requiring its appeal request demonstrate that each of the Providers satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves a payment determination ***retroactively*** *applicable to them* under the terms of the Final Rule. This finding serves as an alternative and *independent* basis for the Board's dismissal of these appeals.

[78] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

D. The Providers' Appeal Requests Pertains to Multiple Years, in violation of Board Rules

Board Rule 12.5 reads, in pertinent part:

> A group may cover ***only*** *one calendar year* ***unless*** *the Board allows the group to be expanded*. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, a group may submit a written request to include more than one calendar year if it cannot meet the minimum number of provider or the $50,000 amount in controversy requirements.[79]

Here, the instant appeals pertain to multiple years in violation of Board Rules as recognized in the group statements: "The Office of Hearings Case and Document Management System ("OH CDMS") portal does not accommodate Federal Register Notice appeal, like this appeal, that affect more than two cost reporting periods. Thus, to comply with the Board's filing requirements, Providers have identified the first and final cost reporting periods affected by the Final Rule in their OH CDMS submissions."[80]

However, the Board finds the Providers failed to comply with the Board's governing regulations and rules limiting group appeals to one year unless approved by the Board in advance. The Group Representative did not obtain approval from the Board prior to filing. These procedural violations augment the bases for dismissal made in Section C above and further illustrate how the appeals are fatally flawed.

Conclusion:

In summary, the Board finds that:

(1) The Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a);

(2) The Providers did not properly appeal the *alleged* publication of the SSI fractions for unspecified years on or about October 15, 2023; and

(3) Even if the June 2023 Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal request failed to meet the content requirements under 42 C.F.R. § 405.1837(c) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule.

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[79] (Emphasis added.)
[80] Statement on Multi-Year Impact of Final Rule in PRRB Case No. 24-0317G (Dec. 2, 2023).

Based on the foregoing, the Board hereby dismisses the 5 group appeals listed in **Appendix A** in their entirety 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/26/2024

X Clayton J. Nix

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

Enclosure: **Appendix A** – Listing of 4 CIRP Groups and 1 Optional Group

cc: Michael Redmond, Novitas Solutions, Inc. (J-L)
Jacqueline Vaughn, OAA
Wilson Leong, FSS

APPENDIX A
Listing of 5 CIRP and Optional Groups

CASE NO.	CASE NAME
24-0317G	Bass, Berry & Sims, PLC CY 2023 DSH Part C Days Final Rule Group
24-0336GC	CarePoint Health CY 2023 DSH Part C Days Final Rule CIRP Group
24-0354GC	Capital Health CY 2023 DSH Part C Days Final Rule CIRP Group
24-0361GC	Hackensack Meridian CY 2023 DSH Part C Days Final Rule CIRP Group
24-0367GC	Virtua Health System CY 2023 DSH Part C Days Final Rule CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
4000 Meridian Blvd.
Franklin, TN 37067

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

RE: ***Board Decision*** **– SSI Percentage (Provider Specific) Issue**
Abilene Regional Medical Center (Provider Number 45-0558)
FYE: 08/31/2018
Case Number: 22-0461

Dear Mr. Summar 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. 22-0461***

On **August 12, 2021**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2018.

On **January 19, 2022**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4 and 5 to Community Health group appeals. Issues 3 was withdrawn. The remaining issue in this appeal is Issue 1, DSH SSI Percentage (Provider Specific).

[1] On August 15, 2022, the Provider transferred the issue to PRRB Case No. 21-1206GC.
[2] On January 2, 2024, the Provider withdrew this issue.
[3] On August 15, 2022, the Provider transferred the issue to PRRB Case No. 20-2149GC.
[4] On August 15, 2022, the Provider transferred the issue to PRRB Case No. 21-0066GC.

On **September 7, 2022**, the Provider timely filed its preliminary position paper.

On **December 21, 2022**, the Medicare Contractor timely filed its preliminary position paper.

On **March 18, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. To date, no response has been received.

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

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

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

The group issue statement in 21-1206GC, CHS CY 2018 DSH SSI Percentage CIRP Group, to which the Provider is a participant, states, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[5] Issue Statement at 1 (Jan. 19, 2022).

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww (d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA records,

2. Paid days vs. Eligible days,

3. Not in agreement with provider's records,

4. Fundamental problems in the SSI percentage calculation,

5. Covered days vs. Total days and

6. Failure to adhere to required notice and comment rulemaking procedures.[6]

On September 7, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Issue #1: Provider Specific

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

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

> records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt, 545 F. Supp. 2d 20 (D.D.C. 2008).*[7]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH Payment/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 intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[8]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH- SSI Percentage (Systemic Errors) issue, which has been transferred to PRRB Case No. 21-1206GC, are considered the same issue by the Board, is in violation of PRRB Rule 4.6, and should be dismissed.[9]

Lastly, Issue 1 should be dismissed because the Provider failed to file a complete position paper

[7] Provider's Preliminary Position Paper at 8-9 (September 7, 2022).
[8] Jurisdictional Challenge at 6-7 (March 18, 2024).
[9] *Id*. at 4-6.

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]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, 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 jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the 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. As set forth below, the Board should dismiss both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/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."[12] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ."

[10] *Id*. at 7-10.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[12] Issue Statement at 1.
[13] *Id.*

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."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC 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 should find the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board should dismiss this aspect of the DSH Payment/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, the Provider is pursuing that issue as part of the group under Case No. 21-1206GC, 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.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 21-1206GC.

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

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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[14] *Id.*
[15] PRRB Rules v. 3.1 (Nov. 2021).
[16] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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.[17]

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionateshare-data-dsh [18]

[17] (Emphasis added).
[18] Last accessed April 29, 2024.

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."[19]

Accordingly, the Board should find that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue.[20] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board should dismiss this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain, the Board hereby closes Case No. 22-0461 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.

[19] Emphasis added.
[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group, per 42 C.F.R. § 405.1837(b)(1).

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/29/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nan Chi, Director of Budget/Compliance
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: ***Board Dismissal of DSH Payment -Provider Specific Issue***
Houston Methodist Sugarland Hospital (Provider Number 45-0820)
FYE: 12/31/2017
Case Number: 23-1669

Dear Ms. Chi,

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. 23-1669*

On March 17, 2023, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On September 12, 2023, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

1. DSH Payment/ Provider Specific
2. DSH Payment - Systemic Errors
3. DSH Payment-Medicare Part C Days
4. DSH Payment – Medicare Dual Eligible Days
5. DSH Payment – Medicaid Part C Days
6. DSH Payment – Medicaid Dual Eligible Days
7. Standardized Payment Amount

As the Provider is commonly owned/controlled by Houston Methodist Hospital System ("Houston Methodist,") it is, thereby, subject to the mandatory Common Issue Related Party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). Therefore, on April 17, 2024, the Provider transferred Issues 2 through 7 to various Houston Methodist CIRP groups. As a result, the only remaining issue in this appeal is Issue 1, DSH Payment/ Provider Specific.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1609GC

In its Individual Appeal Request, the Provider summarizes its DSH Payment -Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

As noted above, the Provider transferred its Issue 2 – DSH Payment – Systemic Errors to the Houston Methodist CY 2017 DSH SSI Percentage CIRP Group under Case No. 20-1609GC, on April 17, 2024. The Group Issue Statement in Case No. 20-1609GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.

[1] Issue Statement at 1 (Sept. 12, 2023).

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.[2]

The amount in controversy in the Provider's individual appeal request is listed as $123,135 for Issue 1 and $123,134 for Issue 2.

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 Errors) issue that was appealed in PRRB Case No. 20-1609GC.

The DSH Payment– 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."[3] The Provider's legal basis for its DSH Payment–Provider Specific issue asserts that the Medicare Contractor "did not determine

[2] Group Issue Statement, Case No. 20-1609GC.
[3] Issue Statement at 1.

Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[4] 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."[5]

The Provider's DSH – SSI Percentage (Systemic Errors) issue in group Case No. 20-1609GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment – Provider Specific issue in this appeal is duplicative of the DSH – SSI Percentage (Systemic Errors) issue in Case No. 20-1609GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[6], the Board dismisses this aspect of the DSH Payment–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, the Provider is pursuing that issue as part of the group under Case 20-1609GC. 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.[7] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1609GC.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-1609GC 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 Payment –Provider Specific issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment– 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.

---

[4] *Id.*
[5] *Id.*
[6] PRRB Rules v. 3.1 (Nov. 2021).
[7] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

In summary, the Board hereby dismisses the DSH Payment–Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 20-1609GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 23-1669 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/29/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
James Ravindran, Quality Reimbursement Services, Inc. (Rep of Case 20-1609GC)
Michael Redmond, Novitas Solutions, Inc. c/o Guidewell Source (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Russell Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, #570A
Arcadia, CA 91006

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

RE: ***Board Decision*** **– SSI Percentage (Provider Specific) Issue**
Barnes-Jewish West County Hospital (Provider Number 26-0162)
FYE: 12/31/2018
Case Number: 23-0665

Dear Mr. Kramer 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. 23-0665***

On **August 4, 2022**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2018.

On **January 26, 2023**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment – Medicaid Eligible Days (Provider Specific Appeal)[1]

After the withdrawal of Issue 2, there is one (1) remaining issue in this appeal: Issue 1 (DSH Payment/SSI Percentage (Provider Specific)).

On **January 30, 2023**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

[1] This issue was withdrawn on September 21, 2023.

> 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.[2]

On **September 22, 2023**, the Provider timely filed its preliminary position paper.

On **January 12, 2024**, the Medicare Contractor timely filed its preliminary position paper.

On **February 12, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 23-0186GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

The group issue statement in Case No. 23-0186GC, BJC Healthcare CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group, to which the Provider is a participant, states:

> **Statement of the Issue:**
>
> The Provider(s) protest(s) CMS's policy of excluding unpaid SSI days from the numerator of the Medicare fraction. Despite CMS's seemingly contrary policy of treating unpaid Part A days as days

[2] (Emphasis added).
[3] Issue Statement at 1 (Jan. 26, 2023).

entitled to benefits under Part A, CMS requires that a beneficiary be paid SSI benefits (or "covered" by SSI) during the period of his or her hospital stay in order for such days to be considered "entitled to supplemental security income benefits" and included in the numerator of the SSI fraction.

CMS does not include days in the numerator of the SSI fraction when individuals were eligible for SSI but did not receive a SSI payment during their hospitalization for such reasons as failure of the beneficiary to have a valid address, representative payee problems, Medicaid paying for more than 50 percent of the cost of care in a medical facility, or the period of hospitalization is during the first month of eligibility before a cash payment is made. None of these reasons affect the patient's indigency.

CMS's policy of applying different interpretations to the same term, "entitled," used in the same sentence of the statute is the epitome of arbitrary and capricious agency action and must be reversed. *See Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 20 n.1 (D.C. Cir. 2011) (Kavanaugh, J. concurring) ("HHS thus interprets the word 'entitled' differently within the same sentence of the statute. The only thing that unifies the Government's inconsistent definitions of this term is its apparent policy of paying out as little money as possible. I appreciate the desire for frugality, but not in derogation of law."); *see also Walter O. Boswell Mem'l Hosp. v. Heckler*, 749 F.2d 788, 799 (D.C. Cir. 1984) ("It would be arbitrary and capricious for [the Secretary] to bring varying interpretations of the statute to bear, depending upon whether the result helps or hurts Medicare's balance sheets. . . .").

In rulemaking, commenters specifically requested that CMS include other payment codes that identified "entitled" individuals, but the Secretary nonetheless adopted a policy of including only codes that identify people receiving actual SSI cash payment. Id. For example, commenters requested that codes S06 (suspended payment because recipients' whereabouts are unknown based on "undeliverable checks, mail, reports of change or change of address") and S07 ("checks returned for reasons that are unclear or for reasons other than address or a representative payee problem") be included. CMS refused the suggestion.

Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same

> interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes as it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect *eligibility* for SSI benefits.[4]

On September 22, 2023, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Issue #1: Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2).[5]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "[T]he Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper."[6] The MAC also argues the appeal is premature:

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[4] Group Issue Statement, Case No. 23-0186GC.
[5] Provider's Preliminary Position Paper at 7-8 (Sept. 22, 2023).
[6] Jurisdictional Challenge at 5 (Feb. 12, 2024).

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The provider's appeal is premature. 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 PRRB dismiss this issue consistent with recent jurisdictional decisions.[7]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in PRRB Case No. 23-0186GC are considered the same issue by the Board.[8]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[9] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper."[10]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, 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

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[7] *Id*. at 6.
[8] *Id*. at 3-5.
[9] *Id*. at 6.
[10] *Id*. at 8.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

$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 analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the 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. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue that was appealed in PRRB Case No. 23-0186GC.

The DSH Payment/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."[12] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] 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."[14]

The Provider's DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in group Case No. 23-0186GC 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 argues CMS' definition of the term "entitled." Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Unduly Narrow Definition of SSI Entitlement issue in Case No. 23-0186GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[15] the Board dismisses this aspect of the DSH Payment/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, the Provider is pursuing that issue as part of the group under Case No. 23-0186GC, 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

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 3.1 (Nov. 2021).

but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 23-0186GC.

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. 23-0186GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[17]

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,

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

[17] (Emphasis added).

> [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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [18]

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."[19]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 23-0186GC are the same issue.[20] 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 Payment/SSI Percentage (Provider Specific) issue.

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[18] Last accessed April 29, 2024.
[19] (Emphasis added).
[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a BJC Healthcare CIRP group, per 42 C.F.R. § 405.1837(b)(1).

Additionally, in its Preliminary Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-2)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Preliminary Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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*.[21]

Therefore, the Board finds that the Provider did not comply with the Preliminary Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the issue.

2. Second Aspect of Issue 1

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

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board dismisses this aspect of the appeal.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 23-0186GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 23-0665 and removes it from the Board's docket.

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[21] (Emphasis added).

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

For the Board:

4/29/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
360 W Butterfield Rd. Suite 310
Elmhurst, IL 60126

RE: ***Board Decision***
SRI Aurora 2007 Medicaid Eligible Medicare Unmatched Days CIRP Group
Case No. 14-1575GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 14-1575GC pursuant to a Jurisdictional Challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's analysis and determination is set forth below.

Background

On **December 6, 2013**, the Group Representative, Strategic Reimbursement Group ("SRG") filed a group appeal request to establish this CIRP group case. Upon establishment of the group, two providers were transferred in:

1). Aurora Kenosha Medical Center (Prov. No. 52-0189) 13-2996
2). Aurora Sinai Medical Center (Prov. No. 52-0064) 13-3385

On **February 6, 2014**, the Medicare Contractor filed a Jurisdictional Challenge[1] asserting that the group improperly contains 2 issues, one related to DSH and another to LIP. On **April 7, 2014**, the Provider filed its response asserting that they were the same issue.

On **August 22, 2014**, two additional Providers were transferred into the group:

3.) Auroa Health Center Oshkosh (52-0198) from Case No. 14-1632
4.) Aurora Sheboygan Memorial Medical Center (52-0035) from Case No. 14-1631

Both of these providers appealed from RNPRs dated January 6, 2014.

On **December 8, 2021**, SRG filed notice that the Group was fully formed.

[1] The February 6, 2014, Jurisdictional Challenge makes similar arguments as February 21, 2024 Jurisdictional Challenge.

On **December 10, 2021**, the Board issued Notice of the CIRP Group Fully Formed and Critical Due Dates that set deadlines for the parties' preliminary position paper filings. The Notice included the following instructions for the Group's preliminary position paper filing:

> Group's Preliminary Position Paper – 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 Group 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.

On **April 14, 2022**, the Provider filed its Preliminary Position Paper. Similarly, **on August 5, 2022**, the MAC filed its Preliminary Position Paper.

On **February 1, 2024**, the Provider filed its Final Position Paper. Similarly, on February 27,2024, the MAC filed its Final Position Paper.

On **February 21, 2024**, the MAC filed an additional Jurisdictional Challenge requesting dismissal of 2 participants which appealed from an RNPR, dismissal of the LIP issue as an improper second issue which only pertains to one participant (Aurora Sinai Medical Center, Pro . No. 52-0064); and dismissal of the group due to the failure to properly brief the merits of the case in its position paper filings. The Provider had 30 days to file a response, but failed to do so.

MAC's Contentions

The MAC maintains there are three impediments in the Providers appeal. First, Providers 52-0035 (Aurora Sheboygan Memorial Medical Center) and 52-0198 (Aurora Medical Center Oshkosh) are appealing from a RNPR where no adjustments were made for the issue. "The item at issue in this group appeal, Medicaid Eligible Days in the Medicaid Fraction, was not adjusted in the challenged providers' RNPR. Thus, there was no MAC final determination for this issue made on the RNPR determination that is the basis of the appeal."[2]

Second, the group issue statement included both the Operating Disproportionate Share Hospital (DSH) payment, reimbursed under the Inpatient Prospective Payment System (IPPS), and the Inpatient Rehabilitation Facility (IRF) Low Income Payment (LIP). The MAC argues the Providers have appealed more than one issue in the appeal as the DSH and LIP payments are separate and distinct payments.

Lastly, the Group has not specified or adequately briefed its appeal request and position paper in accordance with Board Rules 7, 23 and 25. "The Group has not identified any specific discrepancies or provided any documentation to support its assertion that the SSI percentages are

[2] MAC Jurisdictional Challenge at 4

flawed. Furthermore, if the Group does not have the information needed to properly form its group case, necessary information should be requested prior to the critical due dates."[3]

The MAC requests that the Board dismiss Aurora Medical Center Oshkosh (Provider No. 52-0198), and Aurora Sheboygan Memorial Medical Center (Provider No. 52-0035) from this appeal in accordance with 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889. Further, the MAC request the Board to dismiss this case in its entirety because the providers are appealing more than one issue in a group appeal and the providers failed to properly brief the issues in this appeal.

Provider's Jurisdictional Response

Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." To date, the Provider has not filed a response to the MAC's Jurisdictional Challenge. The Provider had until March 27, 2024, to file a timely response.

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. RNPR Appeals

There are 2 Providers appealing from a RNPR:

- Auroa Health Center Oshkosh (52-0198) from 14-1632
- Aurora Sheboygan Memorial Medical Center (52-0035) from 14-1631

The regulations at 42 C.F.R. § 405.1889 provide details on the right to a hearing pursuant to a RNPR. Specifically, 42 C.F.R. § 405.1889 states:

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

[3] *Id.* at 7

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

Further, as addressed in the regulations at 42 C.F.R. § 405.1887(d):

> (d) A reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision (as described in § 405.1889 of this subpart).

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under § 405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the Contractor's revised final determination.

From the review of the appeal request for each provider, Medicaid Days was not the subject of the RNPR appeals. What was revised was the SSI%. As the Medicaid Eligible days issue was not the subject of the underlying adjustments in the RNPR, the Provider has not met the requirements of 42 C.F.R. § 405.1835(a)(1). The adjustment of the SSI% is a separate and distinct issue. Pursuant to 42 C.F.R § 405.1889(b) as cross referenced in § 405.1835(a), the Board hereby dismisses both providers appealing from their RNPRs as the issue under appeal was not specifically adjusted in those RNPRs:

Aurora Medi Center of Oshkosh:

Adjustment No. 4 Ref: 4

WPR: B.3.1

To update the SSI % and calculated DSH % in accordance with CMS Pub 15-II section 3630.1 and 42 CFR 412.106ff

E, Part A, Title XVIII, Hospital, Line 4.00 Percentage of SSI recipient patient days to Medicare Part A patient days. (see instructions)				
1.00	2.81	-0.28	2.53	Replace
E, Part A, Title XVIII, Hospital, Line 4.03 Allowable disproportionate share percentage. (see instructions)				
1.00	3.42	-0.18	3.24	Replace

Sheboygan 52-0035 Adj Report

Adjustment No. 4 Ref: 4

WPR: B.1.1
To adjust the SSI% and DSH % to audited amounts in accordance with CMS Pub 15-II section 3630.1 and 42 CFR 412.106ff

E, Part A, Title XVIII, Hospital, Line 4.00 Percentage of SSI recipient patient days to Medicare Part A patient days. (see instructions)				
1.00	6.45	-0.76	5 69	Replace
E, Part A, Title XVIII, Hospital, Line 4.03 Allowable disproportionate share percentage. (see instructions)				
1.00	7.31	-0.62	6.69	Replace

In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[4]

B. Appropriate Briefing - Appeals

42 C.F.R. § 40.51853(b)(2)-(3) provides the following instruction for the content of position papers and filing of supporting documents/exhibits:

> (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.

Consistent with this regulation, Board Rule 25 (v 3.1) states the following:

> **Rule 25 Preliminary Position Papers**
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the applicable subsection.
>
> **25.1.1 Provider's Position Paper**
>
> The provider's preliminary position paper must:

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

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For each issue that has not been fully resolved, provide a fully developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority, (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

Rule 25.2 Position Paper Exhibits

25.2.1 General
With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted documents

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

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

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

Board Ruel 25 is applicable to final position papers per Board Rule 27.1. The instructions include in the Board Notices setting the deadlines for the position papers filed in this group case.

The Providers' Group Issue Statement reads:

> Medicaid Eligible Medicare Unmatched Days: -
>
> The Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Provider's Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively 'Calculations").
>
> The Provider contends that these days have been incorrectly identified as Medicare days and that they are not included in the Medicare Fraction (or SSI ratio) of the DSH calculation as indicated by CMS. Provider requests that the necessary files be provided to review the Medicare Fraction and determine if the omitted days were or were not included in the Medicare Fraction. The Provider requests any days omitted from their Calculations on the premise that These days were in fact included in the Medicare Fraction, but as a result of review were identified to have not been included in the Medicare Fraction, be instead properly included in the hospital's Calculations in order to correct the Calculations to be consistent with statute 42 U.S.C. 1395ww(d)(5)(F)(vi)(II)

On April 4, 2022, the Group filed its Preliminary Position Paper[5] and its complete "position" reads below:

> **C. Position**
>
> The Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Provider's Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations").
>
> The Provider contends that these days have been incorrectly identified as Medicare days during filing and audit of the hospital's cost report and that they are not included in the Medicare Fraction (or SSI ratio) of the Calculations as indicated by CMS.

[5] The Preliminary Position Paper included two exhibits (P-1, 42 CFR 412.106 and P-2, 42 CFR 412.320)

> The information needed to perform the necessary review of the Calculations is contained in CMS' data sets referred to as "MedPAR SSI Data Files" and had been temporarily unavailable pending the release of CMS' revised SSI ratios. During 2012, CMS issued revised SSI ratios for FFY 2006 – 2010 as required by CMS' Ruling 1498R (April 28th, 2010) and, at the same time, the MedPAR SSI Data Files became available for review by hospitals receiving IPPS DSH payments.
>
> The provider has requested the necessary MedPAR SSI Data Files and is performing a review to identify Medicaid days incorrectly omitted from the Medicaid Fraction of their Calculations. The detailed listing will be provided forthcoming.

The Group did not include any evidentiary exhibits beyond copies of two regulations – 42 C.F.R. §§ 412.106 and 412.320. The Group's final position paper included verbatim the same position and same two exhibits.

The Board finds that the Providers did not file its position papers in accordance with 42 C.F.R. § 405.1853(b)(2)-(3), Board Rules 25 and 27, and the Board Notices setting the deadlines for those filings. The Providers have failed to file a complete position paper pursuant to Board Rules and Regulations because it fails to brief the merits of the providers position but rather is a perfunctory filing with unsupported broad assertions. Further, the Provider has failed to comply with Board Rule 25.2.2 to explain why the SSI MedPAR data is unavailable or why it has failed complete its analysis of that data if its been received. In this regard, the final position paper regurgitates the following statement that suggests that it may have received MedPAR data but fails to provide any finding results:

> The provider has requested the necessary MedPAR SSI Data Files and is performing a review to identify Medicaid days incorrectly omitted from the Medicaid Fraction of their Calculations.

This case has been pending for over 10 years (since December 6, 2013) and yet the Group has failed to fully develop the merits of its case. Accordingly, the Board dismisses the remaining providers and the appeal in its entirety because the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rules 25 and 27, and the instructions included in the Notices setting the position paper filing deadlines.

With respect to the LIP issue raised in connection with only one of the participants, the Board agrees with the Medicare Contractor that it is a separate issue that should have been pursued in a separate appeal. LIP is only for IRFs while DSH pertains only to IPPS hospitals. Further, LIP and DSH are governed by separate statutory authorities. Indeed, the Courts have found that the Board is precluded from reviewing LIP issues. As such, to the extent the LIP issue had been

properly briefed, the Board would still dismiss the LIP issue from this appeal consistent with recent court decisions.[6]

In summary, the Board dismisses the remaining providers in the case, 52-0189 (Aurora Kenosha), 52-0064 (Aurora Sinai). The Providers have failed to develop the merits of their case and submit supporting evidence consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3) and Board Rules 25 and 27, and the instructions included in the Notices setting the position paper filing deadlines. The Board also takes note that the Providers have failed to respond to the Medicare Contractor's Jurisdictional Challenge dated February 21, 2024.

Decision

The Board hereby dismisses the participants under Provider Nos. 52-0035 (Aurora Sheboygan), 52-0198 (Aurora Oshkosh) as the issue appealed by those participants was not specifically adjusted in the RNPRs under appeal, as is required by 42 C.F.R. § 405.1889 as referenced in 42 C.F.R. § 405.1835(a). Further, the Board dismisses the remaining providers and the appeal in its entirety because the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 405.1853(b)(2)-(3), Board Rules 25 and 27, and the instructions included in the Notices setting the position paper filing deadlines.

As the group case has been dismissed in its entirety, the Board hereby closes Case No. 14-1575GC 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole Musgrave, Esq.

For the Board:

4/30/2024

X Clayton J. Nix

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

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

[6] *Mercy Hosp., Inc. v. Azar,* 891 F.3d 1062 (D.C. Cir. 2018), *aff'g*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016). See, e.g., Board Dismissal Decision in Case No. 18-1831 (Dec. 5, 2022) (available at: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-12-1-2022-through-12-31-2022.pdf (last visited Apr. 30, 2024)).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Carol Nave
Absolute Home Health
3656 Ruffin Road, Suite A
San Diego, CA 92123

Pamela VanArsdale
National Government Services, Inc. (J-6)
P.O. Box 6474, MP: INA 101-AF42
Indianapolis, IN 46206-6474

Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***
Absolute Home Health, Provider No. 05-9447, FYE 12/31/2023
Case No. 24-1658

Dear Ms. Nave and Ms. VanArsdale:

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

Pertinent Facts:

On February 27, 2024, Absolute Home Health (the "Provider") filed an appeal with the Board to establish Case No. 24-1658. The appeal was filed from a determination entitled "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("Quality Reporting Determination") dated January 2, 2024.

However, apart from the final determination, and a copy of the Providers "Appeal (to CMS) for Reconsideration of Decision on Quality Reporting Program" ("Reconsideration Request"), the Provider's appeal request did not include:

- A proper issue statement (Board Rule 7.2);
- a complete Representative letter (Board Rule 5.4) and
- a calculation of the reimbursement impact on the facility (Board Rule 6.4).[1]

On February 29, 2024, the Board issued an Acknowledgement and Critical Due Dates Notice in which it set a briefing schedule for the Parties to file preliminary position papers and require the Provider to file the following documentation not included with its appeal request by April 2, 2014: (1) a Representation Letter; and (b) Calculation Support.[2] The deadline for the required support documents was set for March 15, 2024.

[1] Board Rules Version 3.2 (Dec 15, 2023)
[2] After the initial review of the Provider's Reconsideration Letter (which was uploaded in lieu of the Issue Statement), it appeared to partially meet the requirements of an "Issue Statement" so the February 29, 2024 Request for Information did not require an updated Issue Statement be submitted.

When the Provider failed to respond to the request for support documents, the Board issued a final request for the Information on March 18, 2024, giving the Provider a new deadline of April 2, 2024 to submit the required documentation. The letter warned that "[i]f the necessary documentation is not submitted by the deadline, the Board will take action in accordance with 42 C.F.R. § 405.1868" which specifies in subsection (b), in pertinent part, that "[i]f a provider fails to meet a filing deadline or other requirement established by the Boards in a rule or order, the Board may . . . [d]ismiss the appeal with prejudice . . . ." To date, the Provider has not complied with either of the Board's Requests for Information.

Rules/Regulations:

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

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

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

> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.

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

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

Board Determination:

The Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. §§ 405.1837 and 405.1835(b) and with the Board Rules.

First, the Board finds that the document labeled by the Provider as an "Issue Statement" in the Provider's appeal is actually a copy of the Provider's Reconsideration Request. Although initially accepted (***i.e.,*** the Board did not request a revised issue statement), upon further review the Board now finds that this document does not constitute an issue statement consistent with the appeal content requirements in Board Rule 7.2 and 42 C.F.R. § 405.1835(b). Board Rule 7.2 requires, among other things, that an issue statement include adjustment numbers, why the adjustment is incorrect, and a calculation or other support. The Reconsideration Request uploaded by the Provider is merely a statement regarding termination of a Quality Reporting vendor contract. Thus, it does not constitute a proper issue statement as required in Board Rule 7.2 and 42 C.F.R. § 405.1835(b)(1).

Secondly, the Provider's appeal request failed to include calculation support as required under 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4. In lieu of calculation support, the provider submitted an additional copy of the Reconsideration Request. In fact, not only did the Provider submit a copy of the Reconsideration Request in lieu of the Issue Statement, and Calculation Support, but it also submitted it in lieu of the Representative letter, Audit Adjustment Support, and "Other Issue Support."[3]

[3] The Board's March 18, 2024 Request for Information actually specified that the Provider's response should not be another copy of the Reconsideration Request.

Additionally, the Provider listed an estimated reimbursement impact of $1 for the Quality Reporting Program Noncompliance issue. Besides the fact that Provider failed to include a calculation to support this estimate as noted above, the Provider's estimated reimbursement impact fails to meet the $10,000 threshold required for Board jurisdiction of an appeal pursuant to 42 C.F.R. §§ 405.1835(a)(2) and 405.1839.

Finally, the Provider did not file a Representative letter in accordance with Board Rule 5.4. A representative letter is required for all appeals. It must reference the ". . . provider's name, number and fiscal year under appeal." It must also contain the following contact information for the case representative: name, organization, address, telephone number and email address. Again, the Provider uploaded a copy of the Reconsideration Request, but this document fails to meet the requirements as it was not on the Provider's letterhead, does not include the Provider Name, Provider No., nor the cost year under appeal.

The Board finds that the Provider was afforded two separate opportunities to cure the noted deficiencies. The Provider has failed to respond to the Board's February 29, 2024 and March 18, 2024 Requests. Accordingly, pursuant to its authority under 42 C.F.R. §§ 405.1835(b) and 405.1868(b), the Board hereby dismisses Case No. 24-1658 since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above.

Based on the final determination date specified in the appeal request, the Provider may still be within its appeal period. Therefore, if the Provider elects, it may request the Board reconsider its determination and reinstate the appeal. A request for reinstatement must be filed by the appeal filing deadline (see Board Rule 4.4.1) and must include the missing documentation as noted herein. Please see Board Rule 47 regarding reinstatement requirements, as well as 42 C.F.R. § 405.1835 and Board Rules 6 and 7, which discuss *individual provider appeal rights* ***and*** *requirements*. If the reimbursement impact of the appeal is confirmed to be less than $10,000, the Provider may have appeal rights with the Medicare Contractor pursuant to 42 C.F.R. § 405.1839(a)(1).

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

Board Members:
Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/30/2024

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Pamela VanArsdale
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Board Decision* – SSI Percentage (Provider Specific) Issue**
Metrosouth Medical Center (Provider Number 14-0118)
FYE: 12/31/2014
Case Number: 19-0596

Dear Mr. Ravindran and Ms. VanArsdale,

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. 19-0596*

On **May 24, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2014.

On **November 21, 2018**, the Board received the Provider's individual appeal request. The Individual Appeal contained six (6) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. UCC Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]
6. Standardized Payment Amount[5]

[1] On July 1, 2019, this issue was transferred to PRRB Case No. 16-2331GC.
[2] This issue was withdrawn on April 17, 2024.
[3] This issue was withdrawn on August 21, 2023.
[4] On June 19, 2019, this issue was transferred to PRRB Case No. 18-0682GC.
[5] This issue was withdrawn on July 22, 2019.

As the Provider is owned by Quorum Health and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Quorum Health CIRP groups. After the withdrawal of Issues 3, 4 and 6, the remaining issue in this appeal is Issue 1 (DSH Payment/SSI Percentage (Provider Specific).

On **July 16, 2019**, the Provider timely filed its preliminary position paper.

On **November 6, 2019**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.[6]

On **November 13, 2019**, the Medicare Contractor timely filed its preliminary position paper.

On **August 18, 2023**, the Provider changed is designated representative to Mr. Ravindran of Quality Reimbursement Services, Inc. ("QRS").

On **October 11, 2023**, the Board issued a corrected Notice of Hearing and Critical Due Dates, providing among other things, the filing deadlines for the parties' final position papers. This Notice also gave the following instructions to the Provider regarding the content of its final position paper:

> Provider's Final Position Paper – *For each 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 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.[7]

On **February 17, 2024**, the Provider timely filed its final position paper.

On **March 18, 2024**, the Medicare Contractor timely filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 16-2331GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]

[6] The Jurisdictional Challenge also requested the dismissal of Issue 4, but subsequently, this issue was withdrawn.
[7] (Emphasis added).

> . . .
>
> 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.[8]

The group issue statement in Case No. 16-2331GC, Quorum Health 2014 Post 1498R SSI Data Match CIRP Group, to which the Provider transferred Issue 2 reads:

> The failure of the Fiscal Intermediary and [CMS] to properly determine the ratio of patient days for patients entitled to Medicare Part A and [SSI] benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its [DSH] eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for purposes of DSH.
>
> CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments. Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.
>
> On March 22, 2006, the [PRRB] issued a decision in the Baystate case that was favorable to the provider. The PRRB identified significant flaws in the compilation of Medicare SSI days and held, among other things, that: 1) the law requires accuracy in the

[8] Issue Statement at 1 (Nov. 21, 2018).

> reporting of SSI days; 2) the PRRB has the authority to require CMS to recalculate the SSI Percentage if necessary; and 3) there would not be a significant administrative burden required to redesign CMS's computer programs and processes to more accurately identify Medicare SSI eligibility.
>
> The PRRB's decision was supported by the March 31, 2008, D.C. District Court decision which found CMS did not use the most reliable data available to determine which patient days should be counted in the SSI percentage and that such was "arbitrary and capricious." The Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof.
>
> CMS issued Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the DSH calculation.[9]

On **February 17, 2024**, the Provider filed its final 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.

[9] Group Issue Statement, Case No. 16-2331GC.

> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[10]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for several 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 and not a final MAC determination.
>
> . . .
>
> The MAC has not made a determination on the realignment of the SSI percentage to the hospital fiscal year end as the Provider has not yet requested realignment. Since the Provider did not request SSI percentage realignment as required by 42 C.F.R. § 412.106(b)(3), the MAC could not have made a final determination for this Issue. The Provider's appeal is premature. The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this Issue. The MAC requests that the PRRB dismiss the realignment issue consistent with its jurisdictional decisions.[11]

The MAC also mentions that "the Provider did not brief SSI realignment in its position paper."[12]

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[10] Provider's Final Position Paper at 8-9 (Feb. 17, 2024).
[11] Jurisdictional Challenge at 6 (Nov. 6, 2019).
[12] *Id*.

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue that was transferred to PRRB Case No. 16-2331GC are considered the same issue by the Board.[13]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[14] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, 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 jurisdictional analysis for Issue 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[15] into its appeal. As set forth below, the Board should dismiss all aspects of Issue 1.

1. First Aspect of Issue 1

The first and third aspects 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. 16-2331GC.

The DSH Payment/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."[16] The Provider's legal

[13] *Id*. at 3-5.
[14] Board Rule 44.4.3, v. 2 (Aug. 2018).
[15] The Provider has included, as an Exhibit, the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[16] Issue Statement at 1.

basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[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. 16-2331GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 16-2331GC. 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 Payment/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, the Provider is pursuing that issue as part of the group under Case No. 16-2331GC, 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] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue, rather than being subsumed into the "systemic" issue appealed in Case No. 16-2331GC.

To this end, the Board also reviewed the Provider's Final 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. 16-2331GC, 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 Final Position Paper failed to comply with the Board Rule 25 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

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

fully develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

> **25.2 – Position Paper Exhibits**
>
> **25.2.2 Unavailable and Omitted Documents:**
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> 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.

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/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh. [21]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[22]

Accordingly, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue and the group issue from Group Case 16-2331GC are the same issue.[23] 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 Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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*.[24]

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the 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.

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[21] Last accessed April 30, 2024.
[22] Emphasis added.
[23] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Baylor Health CIRP group, per 42 C.F.R. § 405.1837(b)(1).
[24] (Emphasis added).

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 with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 16-2331GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 19-0596 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.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

4/30/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Russell Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, #570A
Arcadia, CA 91006

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

RE: ***Board Decision*** **– Medicaid Eligible Days Issue**
Christian Hospital Northeast-Northwest (Provider Number 26-0180)
FYE: 12/31/2015
Case Number: 19-0753

Dear Mr. Kramer 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. 19-0753***

On **August 22, 2018**, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On **January 24, 2019**, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. DSH Payment/SSI Percentage (Provider Specific)[1]
2. DSH Payment – Medicaid Eligible Days

After the withdrawal of Issue 1, there is one remaining issue in the appeal: Issue 2 (DSH Payment – Medicaid Eligible Days).

On **February 12, 2019**, the Board issued the Notice of Case Acknowledgement and Critical Due Dates, providing among other things, the filing deadlines for the parties' preliminary position papers. This Notice also gave the following instructions to the Provider regarding the content of its preliminary position paper:

> Provider's Preliminary Position Paper – *For each issue*, the position paper ***must*** *state the material facts* that support the appealed claim,

[1] This issue was withdrawn on February 12, 2024.

> 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.[2]

On **September 16, 2019**, the Provider timely filed its preliminary position paper.

On **January 17, 2020**, the Medicare Contractor timely filed its preliminary position paper. With respect to Issue 2, the Medicare contractor requested from the Provider all documentation necessary to resolve the issue in dispute.[3]

On **March 18, 2024**, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 2. To date, and, notably, past the response deadline, no response has been received.

B. Description of Issue 1 in the Appeal Request

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 describes Issue 2 as:

> **Statement of 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.
>
> Audit Adjustment Number(s): 15,16,34,35,37,48,51,52,s-d

[2] (Emphasis added).
[3] Medicare Contractor's Preliminary Position Paper at 11-12 (Jan. 17, 2020).

Estimated Reimbursement Amount: $269,384[4]

Regarding the Medicaid eligible days issue, the Provider argues in its Preliminary Position Paper that, pursuant to the Jewish Hospital case[5] and HCFA Ruling 97-2, "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" of the DSH payment adjustment.[6]

MAC's Contentions

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> 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 Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2015 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 their appeal request.[7]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[8] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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[4] Appeal Request at Issue 2.
[5] *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.,* 19 F.3d 270 (6th Cir. 1994).
[6] Provider's Preliminary Position Paper at 7-8.
[7] Medicare Contractor's Jurisdictional Challenge at 3 (Mar. 18, 2024).
[8] Board Rule 44.4.3, v. 3.2 (Dec. 2023).

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.

The Provider did not include a list of the specific additional Medicaid eligible days that are in dispute in either the initial appeal or the preliminary position paper.

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

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

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

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[9]

Therefore, 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

[9] (Bold emphasis added.)

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

> **Rule 25 Preliminary Position Papers**[10]
>
> **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 The 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**
>
> **25.2.1 General**
>
> With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . . When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4.

[10] (Underline emphasis added to these excerpts and all other emphasis in original.)

> Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to the Board**
>
> Parties should file with the Board a **complete** preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.
>
> **COMMENTARY**: Note that this is a change in previous Board practice. Failure to file a complete preliminary position paper with the Board will result in dismissal of your appeal or other actions in accordance with 42 C.F.R. § 405.1868. (*See* Rule 23.4.)

The Notice of Case Acknowledgement and Critical Due Dates issued to the Provider on February 12, 2019, included instructions on the content of the Provider's preliminary position paper consistent with the above-referenced Board Rules and regulations along with direction to the Provider to refer to Board Rule 25.

Moreover, in connection with Issue 2, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish ***each*** *Medicaid eligible day* being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(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.[11]

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

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

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

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

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

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

Finally, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[12] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. As the Provider failed to identify even a

[11] (Emphasis added.)
[12] (Emphasis added.)

single Medicaid eligible day as being in dispute as part of the position paper filing (much less provider the § 412.106(b)(iii) supporting documentation), notwithstanding its obligations under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25, the Board finds that there are no such days in dispute and that the actual amount in controversy is $0.

Based on the above, the Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute (a material fact) and the timely submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[13]

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In summary, the Board dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As there are no issues remaining in the appeal, the case is now closed.

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

For the Board:

4/30/2024

X Kevin D. Smith, CPA

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

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

[13] *See also Evangelical Commty Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 at *5 (D.D.C. 2022):
> The Board acts reasonably, and not arbitrarily and capriciously, when it applies its "claims-processing rules faithfully to [a provider's] appeal." *Akron*, 414 F. Supp. 3d at 81. The regulations require that a RFH provide "[a]n explanation [ ]for each specific item under appeal." 42 C.F.R. § 405.1835(b)(2). The Board rules further explain that "[s]ome issues may have multiple components," and that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible." Board Rules § 8.1. The Board rules also specifically delineate how a provider should address, as here, a challenge to a Disproportionate Share Hospital reimbursement. Board Rule 8.2 explains that an appeal challenging a Disproportionate Share Hospital payment adjustment is a "common example" of an appeal involving issues with "multiple components" that must be appealed as "separate issue[s] and described as narrowly as possible." Board Rules §§ 8.1, 8.2.