DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Brent Wilson
Quorum Health
1573 Mallory Ln., Ste. 100
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RE: ***Board Decision***
Lock Haven Hospital (Prov. No. 39-0071)
FYE 06/30/2017
Case No. 19-2771

Dear Mr. Wilson:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-2771 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. 19-2771*

On February 28, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for the fiscal year ending June 30, 2017 ("FY 2017").

On August 29, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

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

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 CIRP groups on March 23, 2020. As a result, the remaining issues in this appeal appeal are Issues 1, 3, and 4.

On April 22, 2020, the Provider filed its preliminary position paper.

[1] On March 23, 2020, this issue was transferred to PRRB Case No. 20-1339GC.
[2] On March 23, 2020, this issue was transferred to PRRB Case No. 20-1340GC.

On July 2, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 4. The Provider failed to respond within the 30-day period allotted under Board Rule 44.4.3:

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

On August 13, 2020, the Medicare Contractor filed its preliminary position paper.

On January 11, 2023, the Medicare Contractor filed its 3rd and Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days (*i.e.*, by February 10, 2023). On February 28, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1339GC

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]

As the Provider is commonly owned by Quorum Health, the Provider transferred its Issue 2 – DSH/SSI to the CIRP group under Case Number 20-1339GC, Quorum Health CY 2017 DSH SSI Percentage CIRP Group, on March 23, 2020. The Group Issue Statement in Case No. 20-1339GC 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

[3] Issue Statement at 1 (Aug. 29, 2019).

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $5,000.

On April 22, 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 their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare

[4] Group Issue Statement, Case No. 20-1339GC.

> 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).[5]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final 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 Board dismiss this issue consistent with recent jurisdictional decisions.[6]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[7]

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 supports of its claim for additional Medicaid Eligible Days or

[5] Provider's Preliminary Position Paper at 8-9 (Apr. 22, 2020).
[6] Jurisdictional Challenge at 7 (July 2, 2020).
[7] *Id*. at 6.

describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[8]

Accordingly, the Medicare Contractor requests that the Board dismiss Issue 3.

Issue 4 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[9]

The MAC also contends that this issue is a duplicate of PRRB Case Nos. 16-0769GC and 17-1150GC, and should therefore, be dismissed.[10]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] 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 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 resepct 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 (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

[8] Motion to Dismiss at 6 (Feb. 28, 2023).
[9] Jurisdictional Challenge at 10.
[10] *Id*. at 11.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

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 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 is dismissing 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. 20-1339GC.

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."[12] 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)."[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 Percentage (Systemic Errors) issue in group Case No. 20-1339GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH – SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH – SSI Percentage (Systemic Errors) issue in Case No. 20-1339GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6[15], the Board dismisses this aspect of the DSH – SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-1339GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1).

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[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 2.0 (Aug. 2018).

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] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1339GC.

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. 20-1339GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[17] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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[16] 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).

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

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

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

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-1339GC 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 – 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 from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to

[18] Last accessed February 24, 2023.
[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 Quorum CIRP group per 42 C.F.R. § 405.1837(b)(1).

indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 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.[21]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[22]

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.

[21] Individual Appeal Request, Issue 3.
[22] Provider's Preliminary Position Paper at 8.

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.[23]

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*.[24]

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,[25] Board Rule 25.2 (A) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] 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:

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[23] *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.

[24] (Emphasis added).

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

[26] (Emphasis added).

> *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.[27]

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

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

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[28] 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

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

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 (B). Indeed, without any days identified in the final 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 fact plus the Provider's failure to respond to either the Medicare Contractor's request for the listing and the Medicare Contractor's motion to dismiss, the Board must assume 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 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 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.[29]

Accordingly, the Board hereby dismisses the DSH Payment – Medicaid Eligible Days issue.

C. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).[30]

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[31]
>
> (B) Any period selected by the Secretary for such purposes.

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[29] 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.

[30] The Provider was also a participant in PRRB Case Nos. 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015 and covers service dates July 1, 2016 through Sept. 30, 2016) and 17-1150GC (appealing from the Fed. Reg. dated Aug. 22, 2016 and covers service dates Oct. 1, 2016 through June 30, 2017). Both CIRP Group appeals have been dismissed for a lack of jurisdiction.

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

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[32] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[33] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[34] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[35]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[36]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[37] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no

[32] 830 F.3d 515 (D.C. Cir. 2016).
[33] 89 F. Supp. 3d 121 (D.D.C. 2015).
[34] 830 F.3d 515, 517.
[35] *Id.* at 519.
[36] *Id.* at 521-22.
[37] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

way to review the Secretary's method of estimation without reviewing the estimate itself."[38] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[39]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[40] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[41] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[42] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[43] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[44]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[45]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates

[38] *Id.* at 506.
[39] *Id.* at 507.
[40] 514 F. Supp. 249 (D.D.C. 2021).
[41] *Id.* at 255-56.
[42] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[43] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[44] *Id.*
[45] *Id.* at 262-64.

used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[46] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[47] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[48]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[49] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[50] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[51] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[52] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[53] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[54]

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[46] *Id.* at 265.
[47] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[48] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[49] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[50] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[51] *Id*. at *4.
[52] *Id.* at *9.
[53] 139 S. Ct. 1804 (2019).
[54] *Ascension* at *8 (bold italics emphasis added).

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Provider here is challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

In the alternative, the Board would dismiss the UCC issue because it was abandoned in the Provider's Preliminary Position paper submitted on April 22, 2022. The Provider's Preliminary Position Paper addressed only two issues:

1. Whether the correct SSI percentage was used in the DSH calculation, and
2. Whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such days were paid days.

As discussed above, 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.

As the Provider did not include ***any*** arguments related to the UCC issue, the Board determines that the issue has been abandoned and dismisses it from the appeal.

Decision

The Board hereby dismisses the DSH – SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the common issue in the CIRP group under Case No. 20-1339GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue.

The Board also dismisses the DSH – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue.

Finally, the Board dismisses the UCC Distribution Pool issue because it does not have jurisdiction since 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of the aspects of the UCC payment calculation that the Provider appealed.

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

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For the Board:

5/1/2023

X Clayton J. Nix

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Chair
Signed by: PIV

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Middlesex Hospital (Provider Number: 07-0020)
FYE: 09/30/2014
Case No. 17-1999

Dear Mr. Ravindran and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-1999 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 17-1999*

Middlesex Hospital appealed a Notice of Program Reimbursement ("NPR") dated February 15, 2017, for its fiscal year end September 30, 2014. On August 9, 2017, the Provider filed an individual appeal request which contained the following issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment/SSI Percentage[1]
3. DSH Payment - SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment - Medicaid Fraction/Medicare Managed Care Part C Days[4]

[1] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0863G.
[2] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0869G.
[3] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0867G.
[4] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0872G.

6. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[5]
7. DSH Payment – Medicaid Eligible Days
8. DSH Payment - Medicare Managed Care Part C Days[6]
9. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[7]
10. DSH – Medicaid Eligible Patient Days – Connecticut State Administered General Assistance: DSH Payment Adjustment[8]

The Provider transferred issues 2-6 and 8-10 to group cases. The only issues remaining in this appeal are Issue 1, the DSH SSI Percentage (Provider Specific) issue, and Issue 7, the Medicaid Eligible Days issue.

On March 15, 2023, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1, the DSH/SSI Percentage (Provider Specific) issue. Significantly, the Provider did not file a response to the Jurisdictional Challenge within the 30 days allotted under Board Rule 44.4.3 which specifies:

> Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0863G

In its Individual Appeal Request, the Provider summarizes its 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.

[5] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0868G.
[6] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0872G.
[7] On March 23, 2018, this issue was transferred to PRRB Case No. 17-0868G.
[8] On January 29, 2018, this issue was transferred to PRRB Case No. 18-0598G.

> 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).
>
> 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.[9]

The amount in controversy was listed as $102,000.[10]

Issue 2 was transferred to Case No. 17-0863G, *QRS 2014 DSH SSI Percentage Group*, and the group issue statement in Case No. 17-0863G states:

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

[9] Provider's Request for Hearing, at Issue Statement, Issue 1 (Aug. 9, 2017).
[10] *Id.*

> 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 Providers further contend that the SSI percentages calculated by [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 . . . are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the *Baystate* case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days.[11]

The amount in controversy for Provider No. 07-0020 in Case No. 17-0863G is $102,000, the same amount as Issues #1 and 2 in the individual appeal.[12]

On February 6, 2023, 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**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:

[11] *See* Group Issue Statement, PRRB Case No. 17-0863G.
[12] *See* Requests for Hearing in PRRB Case Nos. 17-1999 and 17-0863G.

Provider Specific

The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.

The Provider has worked with the State of Connecticut 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/OTS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of those errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[13]

MAC's Contentions

The MAC first notes that the Provider's individual appeal request includes three sub-components for Issue 1: (1) SSI data accuracy, (2) SSI realignment, and (3) individuals who are eligible for SSI but did not receive SSI payment. The MAC argues that sub-issues (1) and (3) should be dismissed as duplicative of Issue 2 of the individual appeal (which was transferred to group appeal 17-0863G). The MAC contends that PRRB Rule 4.6.1 prohibits duplicate appeals.[14]

Further, the MAC argues that the Provider's appeal over sub-issue (2), the SSI realignment, has been abandoned because the Provider did not brief this issue in its preliminary position paper. Alternatively, the MAC asserts that the appeal of this issue is premature because the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R.

[13] Provider's Final Position Paper at 8-9 (Feb. 6, 2023).
[14] MAC's Jurisdictional Challenge (Mar. 15, 2023).

§ 412.106(b)(3), and has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.[15]

Lastly, the MAC asserts that Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and PRRB Rule 25.[16]

Provider's Response

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

Board Analysis and Decision

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

A. DSH SSI Percentage (Provider Specific)

The analysis for Issue 1 has three 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 arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction.

1. First and Third Aspects of Issue 1

The first aspect of Issue 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 issue that was transferred to PRRB Case No. 17-0863G.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[17] The Provider's legal basis for its DSH/SSI

[15] *Id.*
[16] *Id.*
[17] Issue Statement at 1.

- Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH SSI Percentage issue in group Case No. 17-0863G 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 issue in Case No. 17-0863G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[20], 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 No. 17-0863G. 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 can be distinguished from its second SSI percentage issue rather than being subsumed into the issue appealed in Case No. 17-0863G.

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. 17-0863G, 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 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. For example, the Provider indicates that its arguments are based on "certain data from

[18] *Id.*
[19] *Id.*
[20] PRRB Rules v. 1.3 (July 2015).
[21] 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 State of Connecticut and the Provider that does not support the SSI percentage issued by CMS" but has not provided that certain data.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[22]

[22] Last accessed May 2, 2023.

> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

The Board also finds that the third aspect of Issue 1, the Provider arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction is duplicative of the issue that the Provider transferred to Case No. 17-0863G. In fact, the Provider included essentially the same paragraph discussing this issue in both the individual appeal statement for Issue 1 and the group appeal statement, as follows:

> 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.

As discussed above, the Board has found that the first and third aspects of Issues 1 and the group issue in Group Case 17-0863G, 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 (July 1, 2015), the Board dismisses these components of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules, as described above.

1. 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—was not addressed by the Provider in its final position paper. Nonetheless, the Board finds that this aspect of Issue 1 must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied 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

[23] Emphasis added.

realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.[24]

****

In summary, the Board hereby dismisses the SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 17-0863G and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As one issue remains pending, Case No. 17-1999 will remain open.

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

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For the Board:

5/4/2023

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Board Member
Signed by: Kevin D. Smith -A

cc: Wilson Leong, Federal Specialized Services

[24] Further, the Board notes that since the Provider's cost reporting year end (FYE 9/30) is the same as the federal fiscal year end (9/30), a realignment of the SSI percentage data would have no effect on the SSI, as the same data would be used and the same monthly periods.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Gina Churchill
UCI Health
1500 S. Douglas Road, Suite 200
Anaheim, CA 92806

RE: ***Jurisdictional Decision***
University of California Irvine Medical Center (Prov. No. 05-0348)
FYE 6/30/2011
Case No. 19-1257

Dear Ms. Churchill,

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending June 30, 2011 ("FY 2011"). The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation pursuant to a jurisdictional challenge, filed by the Medicare Administrative Contractor ("MAC"), on November 26, 2019. As set forth below, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities-Low Income Payment ("IRF-LIP") reimbursement portion of several issues and dismisses that portion of those issues from the instant appeal.

Pertinent Facts:

The Board received Provider's Request for Hearing on January 25, 2019, appealing from a Notice of Program Reimbursement ("NPR") dated August 1, 2018. The individual appeal contained the following issues:

- Issue 1: Medicare Settlement Data
- Issue 2: DSH- Inclusion of Medicare Dual Eligible Part A Days in SSI
- Issue 3: DSH- Inclusion of Medicare Part C Days in SSI Ratio[1]
- Issue 4: DSH- Accuracy of CMS Developed SSI Ratio
- Issue 5: DSH- SSI MMA Section 951 Applicable to SSI Ratio
- Issue 6: GME Payment[2]
- Issue 7: IME Payment[3]
- Issue 8: Rural Floor Budget Neutrality Adjustment[4]
- Issue 9: Protested Items

[1] On January 25, 2019, the Board remanded this issue to the MAC pursuant to CMS Ruling 1739-R.
[2] The Provider withdrew this issue on February 9, 2022.
[3] The Provider withdrew this issue on February 9, 2022.
[4] The Provider withdrew this issue on February 9, 2022.

- Issue 10: IME I&R Base Year FTE Counts-Sub providers I & II
- Issue 11: GME I&R Cap Penalty
- Issue 12: Re-billed OP Crossover Bad Debts

The Medicare Contractor filed Jurisdictional Challenges, on November 26, 2019, to Issues 2, 3, 4, 5, 6, and 7. As the Provider has since withdrawn Issues 6 and 7, the Board will not address the jurisdictional challenges to those issues.

For several of the issues, the Provider appealed *both* the Disproportionate Share Hospital ("DSH") payment ***and*** the Low Income Payment ("LIP") issues. The Provider's appeal request reads, in pertinent part:

> **Issue No. 2 - Medicare Disproportionate Share Hospital (DSH) Payments - Inclusion of Medicare Dual Eligible Part A Days in the SSI Ratio Issued March 16, 2012**
> **Adjustment Numbers 4, 5, 21, 66, & 67**
>
> The Provider disputes the SSI percentage developed by CMS and utilized by the FI/MAC in their updated calculation of Medicare Disproportionate Share Hospital (DSH) payment and Low Income Patient (LIP) payment for Inpatient Rehabilitation Facilities, if applicable.
>
> ***
>
> The estimated Medicare reimbursement at issue is $766,414 ($753,068 + $13,346) based upon the exclusion of 3,207 (2,949 + 258) Medicare Dual Eligible Part A Days from the SSI Ratio and inclusion of 3,207 additional Medicare Dual Eligible Part A Days in the Medicaid patient day ratio of the Medicare DSH and LIP (if applicable) payment calculations.
>
> **Issue No. 3 - Medicare Disproportionate Share Hospital (DSH) Payments - Inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio Issued March 16, 2012**
> **Adjustment Numbers 4, 5, 21, 66, & 67**
>
> The Provider disputes the SSI percentage developed by CMS and utilized by the FIIMAC in their updated calculation of Medicare Disproportionate Share Hospital (DSH) payment and Low Income Patient (LIP) for Inpatient Rehabilitation Facilities, if applicable.
>
> ***

The estimated Medicare reimbursement at issue is $17,361 ($16,935 & $426) based upon the exclusion of 79 (69 & 10) Medicare Dual Eligible Part C Days from the SSI Ratio, and inclusion of additional 79 Medicare Dual Eligible Pat C Days in the Medicaid patient day ratio of the Medicare DSH and LIP (if applicable) payment calculations. A calculation supporting this amount is enclosed.

Issue No. 4 - Medicare Disproportionate Share Hospital (DSH) Payments - Accuracy of CMS Developed SSI Ratio Issued March 16, 2012
Adjustment Numbers 4, 5, 21, 66, & 67

The Provider disputes the SSI percentage developed by CMS and utilized by the FI/MAC in their updated calculation of Medicare Disproportionate Share Hospital (DSH) payment and Low Income Patient (LIP) for Inpatient Rehabilitation Facilities, if applicable. The Provider contends CMS failed to disclose the underlying patient data of their calculation proving the SSI ratio issued on March 16, 2012 is calculated in the manner prescribed by CMS Ruling 1498-R. In short, the accuracy of CMS' updated SSI ratio is in question. The applicable Medicare regulations are 42 CFR 412.106 and 42 CFR 412.624. The estimated Medicare reimbursement at issue pertaining to this aspect of the Medicare DSH payment is $113,840 ($112,420 & $1,420) based upon an estimated 2% increase to the Provider's SSI ratios.

Issue No. 5 - Medicare Disproportionate Share Hospital (DSH) Payments - SSI MMA Section 951 Applicable to SSI Ratio Issued March 16, 2012
Adjustment Numbers 4, 5, 21. 66 & 67

Section 951 of the Medicare Modernization Act (MMA) requires the Secretary to arrange to furnish to subsection (d) hospitals (as defined in section 1886(d)(l)(B) of the Social Security Act, 42 U.S.C. 1395ww(d(1)(B)) the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. Such data shall also be furnished to other hospitals which would qualify for additional payments under Part A of Title XVIII of the Social Security Act on the basis of such data.

The Provider contends CMS has failed to comply with Section 951 of the MMA for multiple reasons.

MAC's Jurisdictional Challenge

On November 26, 2019, the Medicare Contractor filed a Jurisdictional Challenge regarding Issues 2, 3, 4, and 5, LIP payment.[5] The MAC contends that the Board does not have subject matter jurisdiction over the LIP calculation. The Inpatient Rehab Facility ("IRF") low income patient ("LIP") adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3)(A)(v). In accordance with § 1395ww(j)(8), there is no administrative or judicial review of the IRF LIP adjustment.

The MAC argues that in this appeal, the Provider challenges the accuracy of the IRF LIP adjustment. The IRF LIP adjustment is a facility-level adjustment for low income patients that takes into account both the percentage of Medicare patients who are receiving Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. The purpose of the LIP adjustment is to pay IRFs more accurately for the incremental increase in Medicare costs associated with the facility's percentage of low-income patients. 42 U.S.C. § 1395ww(8) specifically prohibits and precludes administrative and judicial review of prospective payment rates established under § 1395ww(j)(3).[6]

Additionally, that in responding to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary specifically noted that the LIP adjustment was an adjustment under § 1395ww(j)(3)(A)(v). Because the LIP adjustment is a component of the IRF prospective payment rate established under § 1395ww(j)(3), administrative and judicial review of the LIP adjustment are statutorily precluded by § 1395ww(j)(8). 42 C.F.R. § 405.1867 mandates that the Board must comply with all of the provisions of the Medicare Act and the regulations issued thereunder. Accordingly, § 1395ww(j)(8)(B) precludes administrative review of the IRF-LIP adjustment, and thereby divests the Board of jurisdiction to hear the LIP portions for Issues 2, 3,4 and 5 of the Provider's appeal.

Provider's Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Challenge must filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response 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 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's 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 specific items claimed on a timely filed cost

[5] Medicare Contactor's Jurisdictional Challenge at 1 (November 26, 2019)
[6] *Id*. at 3
[7] Board Rule 44.4., v. 2 (Aug. 29, 2018).

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. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[8]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[9] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[10]

In the instant appeal, the Provider seeks Board review of several of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustments: dual eligible Part A days in the SSI ratio; dual eligible Part C days in the SSI ratio; accuracy of the SSI ratio; and SSI MMA 951 issues. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the LIP portion of issues 2, 3, 4, and 5 in the instant appeal that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision in determining the scope and applicability of the preclusion provisions in42 U.S.C. § 1395ww(j)(8) and notes that,

[8] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).
[9] *Mercy Hosp., Inc. v. Burwell*, 206 F.Supp.3d 93, 102-103 (D.D.C. 2016).
[10] *Mercy*, 891 F.3d at 1068.

consistent with the Administrator's practice, the D.C. Circuit's decision in Mercy is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8) because the Provider could bring suit in the D.C. Circuit.[11]

Conclusion

The Board dismisses the portion of Issues 2, 3, 4, and 5 related to the IRF LIP adjustment issues in its entirety from this appeal. The DSH portion of Issue 3 was remanded pursuant to CMS Ruling 1739-R. The DSH portion of issues 2, 4, and 5 remain pending in the appeal. As there are other active issues in this appeal, Case No. 19-1257 remains open.

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

Board Members Participating:

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

For the Board:

5/5/2023

X Robert A. Evarts, Esq.

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Medical Center of South Arkansas (Provider Number: 04-0088)
FYE: 06/30/2015
Case Number: 18-0105

Dear Messrs. Summar and Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 18-0105 in response to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 18-0105*

Medical Center of South Arkansas appealed a Notice of Program Reimbursement ("NPR") dated April 26, 2017, for its fiscal year end June 30, 2015. On October 19, 2017, the Provider filed an individual appeal request which contained the following issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment/SSI Percentage[1]
3. DSH Payment – Medicaid Eligible Days
4. Uncompensated Care Distribution Pool[2]
5. Dual Eligible Days – SSI Fraction & Medicaid Fraction[3]

As the Provider is part of Community Health Systems, Inc. ("CHS"), the Provider transferred issues 2, 4, and 5 to common issue related party ("CIRP") groups for CHS.

On April 11, 2018, the Medicare Contractor filed a Jurisdictional Challenge regarding the DSH/SSI Percentage (Provider Specific) issue. On February 13, 2023, the Medicare Contractor filed a Motion to Dismiss the DSH Medicaid eligible days issue.

[1] On June 25, 2018, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On June 25, 2018, this issue was transferred to PRRB Case No. 18-0555GC.
[3] On June 25, 2018, this issue was transferred to PRRB Case No. 18-0554GC.

Significantly, the Provider did not file a response to the Jurisdictional Challenge or the Motion to Dismiss within the 30 days allotted under Board Rules 44.4.3 and 44.3, which specify that Providers file a response within thirty (30) days of the Medicare Contractor's jurisdictional challenge or motion, respectively. Board Rule 44.4.3 states that "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

On April 6, 2023, the Provider withdrew the DSH Medicaid eligible days issue, and filed its final position paper. The only issue remaining in this appeal is the DSH SSI Percentage (Provider Specific) issue.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC

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

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

The amount in controversy was listed as $23,000.[5]

Issue 2 was transferred to Case No. 18-0552GC, *QRS CHS 2015 DSH SSI Percentage CIRP Group*, and in the group issue statement in Case No. 18-0552GC, the Providers assert:

> 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 [CMS] and used by the Lead MAC to settle their Cost Report was incorrectly computed.
>
> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. [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 . . . are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the *Baystate* case:

[4] Provider's Request for Hearing, at Issue Statement, Issue 1 (Oct. 19, 2017).
[5] *Id.*

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]

The amount in controversy for Provider No. 04-0088 in Case No. 18-0552GC is $23,000, the same amount as Issues #1 and 2 in the individual appeal.[7]

On April 6, 2023, 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**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> 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 those errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that

[6] *See* Group Issue Statement, PRRB Case No. 18-0552GC.
[7] *See* Requests for Hearing in PRRB Case Nos. 18-0105 and 18-0552GC.

> 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).[8]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH Payment – SSI Percentage (Provider Specific) issue because the Provider is making the same argument as was made in Issue 2 of the individual appeal (which was transferred to group appeal 18-0552GC). Moreover, these issues are considered the same issue by the Board, and the MAC cites several past Board decisions to that end. The MAC contends that Board Rules state that providers are barred from filing duplicate appeals. The Board should find that the SSI percentage is one issue for appeal purposes and dismiss Issue 1.[9]

Further, the MAC argues that the Provider appeal over SSI realignment 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, thus, has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.[10]

Provider's Response

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

Board Analysis and Decision

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

A. DSH SSI Percentage (Provider Specific)

The analysis for Issue 1 has three relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the

[8] Provider's Final Position Paper at 7-8 (Apr. 6, 2023).
[9] MAC's Jurisdictional Challenge (Apr. 11, 2018).
[10] *Id.*

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 arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction.

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage issue that was transferred to PRRB Case No. 18-0552GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[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 issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage 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 4.5[14], 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 18-0552GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[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

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*
[14] PRRB Rules v. 1.3 (July 2015).
[15] 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).

or provide evidence) how the alleged "provider specific" errors can be distinguished from its second SSI percentage issue rather than being subsumed into the issue appealed in Case No. 18-0552GC.

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 (Issue 2) in Case No. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

The Board further notes that 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 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]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]

The Provider indicates that the data made available "lacks all data records necessary to fully identify all patients properly includable in the SSI fraction" but does not explain how the data provided is deficient. Instead, CMS' website explains that what is provided is the same data set CMS uses to calculate the Medicare fractions.

The Board also finds that the third aspect of Issue 1, the Provider arguing over the interpretation of "entitled to" and "eligible for" benefits for purposes of calculating the numerator of the SSI fraction is duplicative of the issue that the Provider transferred to Case No. 18-0552GC. In fact, the Provider included essentially the same paragraph discussing this issue in both Issues 1 and 2, as follows:

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (July 1, 2015), the Board dismisses this third aspect of the DSH/SSI Percentage (Provider Specific) issue.

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[16] Last accessed April 6, 2023.
[17] Emphasis added.

It is noted that the Board has found that the first and third aspects of Issues 1 and the group issue in Group Case 18-0552GC, are the same issue, and has dismissed these components of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 in its entirety for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules, as described above.

1. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for 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, and as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 18-0552GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 18-0105 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:

5/8/2023

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
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Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

RE: ***Jurisdictional Determination in Part***
Toyon 2008 Inclusion of Medicare Part C Days in the SSI Ratio Group
Case Number: 18-0533G

Specifically: Enloe Medical Center (Provider Number: 05-0039)
San Joaquin General Hospital (Provider Number: 05-0167)
Washington Hospital (Provider Number: 05-0195) and
Stanford Health Care – Valleycare (Provider Number: 05-0283)

Dear Mr. Chinea:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over four of the participants that appealed from revised Notices of Program Reimbursement ("RNPRs"). A brief procedural history, the pertinent facts with regard to the appeal of each Provider, and the Board's Determination are set forth below.

Procedural History

The "Toyon 2008 Inclusion of Medicare Part C Days in the SSI Ratio Group" appeal was filed by Toyon on January 22, 2018. The optional group was designated to be complete on March 1, 2019 and includes five active participants:[1]

- Enloe Medical Center (05-0039) ***(RNPR)***
- San Francisco General Hospital (05-0228)
- San Joaquin General Hospital (05-0167) ***(RNPR)***
- Washington Hospital (05-0195) ***(RNPR)*** and
- Stanford Health Care-Valleycare (05-0283) ***(RNPR)***

Each individual appeal for the four respective Providers that appealed from RNPRs included two issues:

[1] The electronic record for the group was populated in the Office of Hearings Case & Document Management System ("OH CDMS") on November 18, 2021.

1. DSH -Accuracy of CMS Developed SSI Ratio
2. DSH- Inclusion of Medicare Part C Days in the SSI Ratio

In each case, Toyon requested the transfer of the two issues from the Provider's individual appeal to two optional groups (that were filed on January 22, 2018) as follows:

- Case No. 18-0532G- Toyon 2008 Accuracy of CMS Developed SSI Ratio Group III and
- Case No. 18-0533G- Toyon 2008 Inclusion of Medicare Part C Days in the SSI Ratio Group

In the individual appeal requests, the DSH – Inclusion of Medicare Part C Days in the SSI Ratio issue was summarized as follows:

> The Provider disputes the SSI percentage developed by CMS and utilized by the MAC in their calculation of the Medicare DSH payment. . . .
>
> The Provider contends CMS' new interpretation of including Medicare Part C Days in the SSI ratio issued is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision. The Secretary did not validly change her interpretation of the DSH calculation prior to FFY 2013, and because there is not statute that authorizes the Secretary to promulgate retroactive rules for the DSH calculations, the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. The Provider's position is supported by the federal district court decision in *Allina Health Services, et al, v. Kathleen Sebelius, Secretary, US Department of Health and Human Services* (Civil Action No. 10-1463 (RMC). The Provider maintains the position only Medicare Part A days should be included in the SSI Ratio and that Medicare Part C days should be excluded. [2]

Background for Providers

A. Enloe Medical Center (05-0039)

The Provider was issued two Notices of Reopening on March 23, 2015 and March 30, 2015. The first Notice of Reopening indicates the reopening is to include additional Eligible Days in accordance with a partial administrative resolution of Case No. 13-1455. The second reopening was issued after a desk review to reflect settlement computations.

The RNPR was issued on June 30, 2017, and included the following adjustments:

[2] Provider Requests for Hearings at 1-2.

#1: Completed cost reporting forms & pages in accd. w/ regulations
#4: Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
#5: Adjust allowable DSH percentage to account for revised SSI percentage
#7: Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE

The Provider transferred to this group from Case No. 18-0343 on January 22, 2018.

B. San Joaquin General Hospital (05-0167)

The Provider's Reopening Request dated March 25, 2013 3/25/2013, ". . . requests a recalculation of its Hospital SSI ratio for purposes of aligning it with the Hospital's fiscal year ended FYE 6/30/2008." Subsequently, the MAC issued the Notice of Reopening on June 5, 2017:

> To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio.

The RNPR was issued on June 29, 2017 and included the following adjustments:

#1: Completed cost reporting forms & pages in accd. w/ regulations
#4: Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
#5: Adjust allowable DSH percentage to account for revised SSI percentage
#7: Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE

The Provider transferred to this group from Case No. 18-0384 on December 17, 2018.

C. Washington Hospital (05-0195)

The Provider was issued a Notice of Reopening dated December 8, 2016:

> To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio.

The RNPR was issued on June 23, 2017 and included the following adjustments:

#1 & 3: Adjustment made to revise the SSI Ratio & the allowable DSH % based on the CMS letter of SSI% Realignment

The Provider transferred to this group from Case No. 18-0385 on August 22, 2018.

D. Stanford Health Care -Valleycare (05-0283)

The Provider's RNPR was issued on June 27, 2017,[3] and included the following adjustments:

#1 Completed cost reporting forms & pages in accd. w/ regulations
#4 Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
#5 Adjust allowable DSH percentage to account for revised SSI percentage
#7 Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE

The Provider transferred to this group from Case No. 18-0386 on August 24, 2018.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), 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 contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

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

[3] The Reopening Request, Notice of Reopening, Revised NPR and Audit Adjustment Pages are not populated in OH CDMS for this participant, nor are they populated in the Provider's individual appeal from which it transferred. The hard copy Schedule of Provider for this Provider included the relevant RNPR and audit adjustment pages.

> (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.[4]

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[5]

The Board has determined that it does not have jurisdiction over the Part C Days issues that were appealed from the RNPRs for Enloe Medical Center (Prov. No. 05-0039); San Joaquin General Hospital (Prov. No. 05-0167); Washington Hospital (Prov. No. 05-0195) and Stanford Health Care – Valleycare (Prov. No. 05-0283). The Board finds that the RNPRs for these four Providers were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the Part C days issue. Thus, the Providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[4] 42 C.F.R. § 405.1889(b).
[5] (Emphasis added).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, it is clear that the revision to the SSI percentage was adjusted only in order to realign it from a federal fiscal year to the providers' respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[7] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Providers are trying to appeal (much less revise any of the Part C days included in the underlying month-by-month data).[8] Since the only matters specifically revised in the RNPRs were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, 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. 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.[9]

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[6] 42 C.F.R. § 405.1889(b)(1).

[7] 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)).

[8] *See supra* n. 8.

[9] *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).

Conclusion

The Board finds that it lacks jurisdiction over Enloe Medical Center (Prov. No. 05-0039); San Joaquin General Hospital (Prov. No. 05-0167); Washington Hospital (Prov. No. 05-0195) and Stanford Health Care – Valleycare (Prov. No. 05-0283) 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. The Board will issue a determination regarding the applicability of CMS Ruling 1739R for the remaining participant in the subject group case under separate cover.

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

Board Members:

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

For the Board:

5/8/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

RE: ***Jurisdictional Determination in Part***

Toyon 2008 Accuracy of CMS Developed SSI Ratio Group III
FYE: 6/30/2008
Case Number: 18-0532G

Specifically: Enloe Medical Center (Provider Number: 05-0039)
San Joaquin General Hospital (Provider Number: 05-0167)
Washington Hospital (Provider Number: 05-0195) and
Stanford Health Care – Valleycare (Provider Number: 05-0283)

Dear Mr. Chinea:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the subject group appeal and notes an impediment to jurisdiction over four of the participants that appealed from revised Notices of Program Reimbursement ("RNPRs"). A brief procedural history, the pertinent facts with regard to the appeal of each Provider and the Board's Determination are set forth below.

Procedural History:

The "Toyon 2008 Accuracy of CMS Developed SSI Ratio Group III" appeal was filed by Toyon on January 22, 2018. The optional group was designated to be complete on March 1, 2019 and includes five active participants:[1]

- Enloe Medical Center (05-0039) ***(RNPR)***
- San Francisco General Hospital (05-0228) (Original NPR)
- San Joaquin General Hospital (05-0167) ***(RNPR)***
- Washington Hospital (05-0195) ***(RNPR)*** and
- Stanford Health Care-Valleycare (05-0283) ***(RNPR)***

[1] The electronic record for the group was populated in the Office of Hearings Case & Document Management System ("OH CDMS") on November 18, 2021.

On June 10, 2019, the Board denied a transfer request for Stanford Health Care (05-0441) from Case No. 18-1040 (which was filed from an original NPR) due to insufficient documentation and failure to follow Board Rules. The provider is included in the participant listing in OH CDMS and reflects the transfer denial.

On April 15, 2020, the Board denied the transfer request for San Francisco General Hospital (05-0228) for FY 6/30/2008 from Case No. 19-2550. The Board denied jurisdiction over the provider's individual appeal which was appealed from a revised SSI Realignment NPR and simultaneously denied the transfer of the CMS Developed SSI Ratio issue to Case No. 18-0532GC.

Each individual appeal for the four respective Providers was filed from receipt of a revised NPR and included two issues:

1. DSH -Accuracy of CMS Developed SSI Ratio
2. DSH- Inclusion of Medicare Part C Days in the SSI Ratio

In each case, Toyon requested the transfer of the two issues from the Provider's individual appeal to two optional groups (that were filed on January 22, 2018) as follows:

- Case No. 18-0532G- Toyon 2008 Accuracy of CMS Developed SSI Ratio Group III and
- Case No. 18-0533G- Toyon 2008 Inclusion of Medicare Part C Days in the SSI Ratio Group[2]
-

In the individual appeal requests, the DSH – Accuracy of CMS Developed SSI Ratio issue was summarized as follows:

> The Provider disputes the SSI Ratio developed by CMS and utilized by the MAC in their calculation of Medicare DSH payment. The SSI ratio is understated due to flaws and inaccuracies in CMS's matching process of Medicare patient records with Social Security Administration records.
>
> Furthermore, CMS refuses to allow Providers access to SSA records, prohibiting the research Providers could take to ensure an accurate SSI ratio.
> . . .
>
> [T]he accuracy of CMS' updated SSI ratio is in question both because of the flaws and inaccuracies present in CMS' matching process of patient records with SSA records, and because CMS violates Providers' legal right to access data necessary to ensure that an accurate SSI Ratio is being calculated.

[2] A jurisdictional determination for the Part C group was issued on May 8, 2023.

Background for Providers

A. Enloe Medical Center (05-0039)

The Provider was issued two Notices of Reopening on March 23, 2015 and March 30, 2015. The first Notice of Reopening indicates the reopening is to include additional Eligible Days in accordance with a partial administrative resolution of Case No. 13-1455. The second reopening was issued after a desk review to reflect settlement computations.

The RNPR was issued on June 30, 2017, and included the following adjustments:

#1: Completed cost reporting forms & pages in accd. w/ regulations
#4: Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
#5: Adjust allowable DSH percentage to account for revised SSI percentage
#7: Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE

The Provider transferred to this group from Case No. 18-0343 on December 17, 2018.

B. San Joaquin General Hospital (05-0167)

The Provider's Reopening Request dated March 25, 2013 3/25/2013, ". . . requests a recalculation of its Hospital SSI ratio for purposes of aligning it with the Hospital's fiscal year ended FYE 6/30/2008." Subsequently, the MAC issued the Notice of Reopening on June 5, 2017:

> To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio.

The RNPR was issued on June 29, 2017 and included the following adjustments:

#1: Completed cost reporting forms & pages in accd. w/ regulations
#4: Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
#5: Adjust allowable DSH percentage to account for revised SSI percentage
#7: Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE

The Provider transferred to this group from Case No. 18-0384 on December 17, 2018.

C. Washington Hospital (05-0195)

The Provider was issued a Notice of Reopening dated December 8, 2016:

> To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio.

The RNPR was issued on June 23, 2017 and included the following adjustments:

> #1 & 3: Adjustment made to revise the SSI Ratio & the allowable DSH % based on the CMS letter of SSI% Realignment

The Provider transferred to this group Case No. 18-0385 on August 22, 2018

D. Stanford Health Care -Valleycare (05-0283)

The Provider's RNPR was issued on June 27, 2017,[3] and included the following adjustments:

> #1 Completed cost reporting forms & pages in accd. w/ regulations
> #4 Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
> #5 Adjust allowable DSH percentage to account for revised SSI percentage
> #7 Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE

The Provider transferred to this group from Case No. 18-0386 on August 24, 2018.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), 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 contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

[3] The Reopening Request, Notice of Reopening, Revised NPR and Audit Adjustment Pages are not populated in OH CDMS for this participant, nor are they populated in the Provider's individual appeal from which it transferred. The hard copy Schedule of Provider for this Provider included the relevant RNPR and audit adjustment pages.

> contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . .

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[4]

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*.
> A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.
>
> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's

[4] 42 C.F.R. § 405.1889(b).

> hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[5]

The Board has determined that it does not have jurisdiction over the DSH – Accuracy of CMS Developed SSI Ratio issues that were appealed from the RNPRs for Enloe Medical Center (Prov. No. 05-0039); San Joaquin General Hospital (Prov. No. 05-0167); Washington Hospital (Prov. No. 05-0195) and Stanford Health Care–Valleycare (Prov. No. 05-0283). The Board finds that the RNPRs for these four Providers were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the DSH – Accuracy of CMS Developed SSI Ratio issue. Thus, the Providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[6] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, it is clear that the revision to the SSI percentage was adjusted only in order to realign it from a federal fiscal year to the providers' respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[7] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail

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[5] (Emphasis added).
[6] 42 C.F.R. § 405.1889(b)(1).
[7] 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)).

re-running of the data matching process that the Providers are trying to appeal.[8] Since the only matters specifically revised in the RNPRs were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, 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 DSH – Accuracy of CMS Developed SSI Ratio issues. 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.[9]

Conclusion

The Board finds that it lacks jurisdiction over Enloe Medical Center (Prov. No. 05-0039); San Joaquin General Hospital (Prov. No. 05-0167); Washington Hospital (Prov. No. 05-0195) and Stanford Health Care–Valleycare (Prov. No. 05-0283) 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.

The Board is transferring the remaining participant in the group, San Francisco General Hospital (Prov. No. 05-0228) back to its pending individual appeal under Case No. 17-1689. Case No. 18-0532G is hereby closed and removed from the Board's docket as there are no remaining participants.

With regard to Case No. 17-1689, the Board notes that a hearing date has been set for February 28, 2024 and that final position papers were previously filed by both Parties in September 2021. Therefore, by November 30, 2023, the Representative is required to file a supplemental final position paper briefing the DSH – Accuracy of CMS Developed SSI Ratio issue. In the alternative, if there is another optional group to which the issue could be transferred, the Representative may do so using the transfer button in OH CDMS. If the issue is not transferred to another group, the Medicare Contractor must file a supplemental final position paper covering the issue no later than December 30, 2023.

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

Board Members:

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

For the Board:

5/12/2023

X Kevin D. Smith, CPA

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

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

[8] *See supra* n. 7.
[9] *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).

Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Determination on Disposition of Fully Formed Single Provider CIRP Group***
SRG Adventist CY 2000 Part C GME CIRP Group
Case Number: 17-1349GC

Dear Mr. Janowski and Ms. Frewert:

On April 6, 2023, the Provider Reimbursement Review Board (the "Board") issued a Request for Information ("RFI") requesting comments regarding the disposition of the subject common issue related party ("CIRP") group because it noted an impediment to the Board's jurisdiction. To date, Strategic Reimbursement Group, LLC ("Strategic") has not responded to the Board's RFI. A brief summary of the pertinent facts and the Board's determination are set forth below.

Background:

On April 14, 2017 Strategic Reimbursement Group ("SRG") filed a Model Form B - Group Appeal Request, to establish the "SRG Adventist 2000 Part C GME CIRP Group." The Board acknowledged the request for hearing on April 18, 2017, to which it assigned Case No. 17-1349GC. Included with the Group Appeal Request were two (2) separate "Model Form D - Requests to Transfer Issue to a Group Appeal" forms for Glendale Adventist Medical Center ("Glendale"/Prov. No. 05-0239): One for fiscal year ("FY") 2000, PRRB Case No: 04-0141, and one for FY 2001, PRRB Case No: 08-1652. These were the only two participants listed on the Schedule of Providers ("SoP") filed with the Group Request.

On May 4, 2017, the Board denied the transfer request of Glendale for FY 2001 to Case No. 17-1349GC. In its determination, the Board advised that Board Rule 12.2 specified that providers in a group appeal must have final determinations for cost reporting periods that end within the same calendar year.[1] Although, the instructions allow for the providers to submit a written request to include more than one year to meet the amount in controversy threshold, no such request was made in this group.

On February 1, 2023, the Board issued a status request in the subject group since no additional providers had been added to the group since its formation, to which Strategic responded on February 7, 2023, designating the group to be fully formed (*with only a single Provider*.)

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

[1] Board Rules v. 1.3 (July 1, 2015). Currently Board Rule 12.5 in v. 3.1 (Nov. 7, 2021).

a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Board Rule 12.5 indicates that "[p]roviders in a group appeal must have final determinations for their cost reporting periods that end with the same calendar year."[2] Although a provider can request to include more than one calendar year to meet the minimum number of providers or the $50,000 amount in controversy requirements, Rule 12.6.1 stipulates that a "CIRP group may be initiated by a single provider under common ownership or control, **but at least two different providers must be in the group upon full formation**."[3] (Emphasis added) Further 42 C.F.R. § 405.1837(b) requires that a group appeal have two or more providers.

Board Rule 18 states that: "After opportunity for comment by the parties, the Board may require a group to restructure appeals either to comply with the law or for judicial economy." In its April 6, 2023 RFI, the Board advised Strategic that its preferred method of handling the disposition of the single participant group would be to merge it with another Adventist Health CIRP group for a later or earlier year. However, based on a search of its database, the Board was unable to locate any other pending groups for the "Part C GME" issue for Adventist Health for another year. Accordingly, the Board provided Strategic the opportunity to comment on its proposal to transfer the group issue back to Glendale's individual appeal for CY 2000 (Case No. 04-0141). The Board advised that the transfer would result in the closure of the CIRP group, Case No. 17-1349GC.

As noted, Strategic failed to respond to the Board's RFI. Accordingly, this letter serves as notice to the Parties that the Board is proceeding with its intended actions and is:

1. Transferring the "Exclusion of Managed Care Days from the GME adjustment" issue from Case No. 17-1349GC back to Glendale Adventist Medical Center's individual appeal under Case No. 04-0141;
2. Closing Case No. 17-1349GC as there are no remaining participants.

By copy of this notification, the Parties are advised that they must brief the "Exclusion of Managed Care Days from the GME adjustment issue" by the deadlines set forth in the April 14, 2023 Notice of Hearing.[4]

The Board reprimands Strategic for its failure to follow Board Rules in that it did not, on its own initiative, request that the Board restructure the group once it realized the group was fully formed with only a single provider (*i.e.* request an expansion of another group in order to consolidate or, in the alternative, transfer the provider back to an individual appeal). Finally, the Board admonishes Strategic for its failure to file comments by the deadline in accordance with the Board's RFI.[5]

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

For the Board:

5/17/2023

X Kevin D. Smith, CPA

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

[2] Board Rules (Aug. 29, 2018, revised Nov. 1, 2021).
[3] Id.
[4] Case No. 04-0141 was recently rescheduled for a hearing date on March 21, 2024.
[5] The Board notes this is the second incident of late where Strategic failed to reply to a Board RFI issued under similar circumstances in Case Nos. 19-1740GC et. al.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
North Shore LIJ 2004 Part C Days CIRP
Case No. 15-1843GC

Dear Ms. Webster:

The above-referenced common issue related party ("CIRP") group appeal[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013."[2]

The subject CIRP group is fully formed.[3] On May 8, 2023, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said ruling.[4] The Board's decision to bifurcate the Provider's EJR Request, and to grant it in part and deny it in part, is set forth below.

Statutory and Regulatory Background

A. Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).
[3] The Board notes that, with respect to fully formed or complete CIRP groups, 42 C.F.R. 405.1837(e)(1) states, in pertinent part: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." (Emphasis added.)
[4] Providers' Petition for Expedited Judicial Review (May 8, 2023).

("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[5] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[6]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[7]

With the creation of Medicare Part C in 1997,[8] 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.[9]

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[5] of Health and Human Services.
[6] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[7] *Id.*
[8] 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.
[9] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice, the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[10]

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."[11] 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.[12]

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.[13] In that publication, the

[10] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[11] 69 Fed. Reg. at 49099.
[12] *Id.* (emphasis added).
[13] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

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).[14] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[15]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[16] 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.[17] In *Allina Health Services v. Price* ("*Allina II*")*,*[18] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[19] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[20] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[21]

B. CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge

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[14] *Id*. at 47411.
[15] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[16] 746 F. 3d 1102 (D.C. Cir. 2014).
[17] *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.").
[18] 863 F.3d 937 (D.C. Cir. 2017).
[19] *Id.* at 943.
[20] Id. at 943-945.
[21] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[22] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[23] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[24]

Regarding EJRs for this Issue, and the fate of this appeal, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals

[22] CMS Ruling 1739-R (Aug. 17, 2020).
[23] *Id*.
[24] *Id*.

> tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[25]

Providers' Request for EJR

The Providers within the CIRP group appeal are challenging their Medicare reimbursement for the fiscal year 2004 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations for periods prior to October 1, 2004 following the decision in *Northeast Hospital*."[26] The Providers further assert that, "the Secretary has recently decided not to comply with the D.C. Circuit's holding in *Northeast*, and the Providers contend that their still uncorrected DSH payment determinations violate the explicit terms of the *Northeast* decision and the agency's policy and practice under the regulation in effect for the periods at issue."[27] Additionally, the Providers argue that issuance of Ruling 1739-R has prevented the Board from calculating DSH amounts that address the Part C days for discharges prior to October 1, 2013, thus the Board lacks the authority to grant the relief requested by the Providers and so the Board is "required" to grant EJR.[28]

The Providers argue that the underlying issue in this case is the same issue that was considered in *Allina I*: "whether 'enrollees in Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction' of the DSH adjustment."[29]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[30] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[31]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without

[25] CMS Ruling 1739-R at 6-7.
[26] Providers' Petition for Expedited Judicial Review, at 1 (May 8, 2023).
[27] *Id*. at 1.
[28] *Id*. at 1-2.
[29] *Id.* at 5, citing *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1105 (D.C. Cir. 2014) ("*Allina I*").
[30] *Id*. at 11-12.
[31] *Id*. at 21.

> violating provisions of the Medicare statute that are binding on the Board here….[32]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz,* 536 U.S. 622, 627 (2002)).[33]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted documentation that establishes their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this *via* the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[34]

Response to Provider's EJR Request

Federal Specialized Services ("FSS") filed a response to the Providers' EJR request on behalf of the MAC on May 12, 2023. The response states:

> The Provider correctly notes that CMS Ruling 1739-R prevents the Board from calculating SSI fractions, Medicaid fractions, and DSH payment amounts for discharges prior to October 1, 2013. The Provider correctly notes that the fiscal year at issue in this case is subject to 1739-R. The Provider fails to note that CMS Ruling 1739-R mandates the remand of the various cases in this CIRP group back to the respective MACs. The Provider's request for expedited

[32] *Id*. at 14.
[33] *Id*. at 14-15.
[34] *Id.* at 18.

judicial review is not appropriate because the Board can issue a determination in this mater – it can remand the cases to the MAC.

The Provider does not challenge the propriety of CMS Ruling 1739-R. Instead, it seeks to use the ruling to circumvent that same ruling. 1739-R is clear in its mandate, these cases must be remanded to the MACs. Accordingly, EJR is not appropriate.

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP groups were established).

A. Board's Authority

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

The Board's analysis is detailed below.

B. Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is

$10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[35, 36]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") and are appealing the periods prior to October 1, 2004.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[37] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[38]

The Board has determined that the participants' appeals involved with the instant EJR are governed by the decision in *Bethesda*. The Providers appealed from original NPRs. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[39] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount. Accordingly, the Board finds that it has jurisdiction for the referenced appeal and the participants.

C. Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[40] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[41] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates *before* October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of

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[35] 42 C.F.R. § 405.1835(a).
[36] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[37] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[38] *Bethesda*, 108 S. Ct. at 1258-59.
[39] *See* 42 C.F.R. § 405.1837.
[40] (Emphasis added.)
[41] CMS Ruling 1739-R at 1-2.

patient days with discharge dates *before* October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[42] To date, CMS has yet to issue its new final rule.[43]

As the Providers' appeals concern the FFY 2003 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e*., the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[44] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e*., determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

D. Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[45]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[46] in which the

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[42] Id. at 2.
[43] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[44] (Emphasis added.)
[45] EJR Request at 17.
[46] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the

providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[47]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration"[48] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[49]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[50] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[47] *See Southwest* at 6-7.

[48] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[49] *See* CMS 1739-R at 8.

[50] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive remand letters of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

5/17/2023

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Danelle Decker, National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Suspension of Record Hearing & Closure Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Medicare Inpatient/Outpatient Unbilled Bad Debt Group Appeals
Case No. 97-2983G, *et al*., on remand[1] (*see* attached list of 27 cases remaining on remand[2])

Dear Messrs. Carlson and Leong,

On February 16, 2021, the Provider Reimbursement Review Board ("Board") reopened the above captioned 27 cases pursuant to the Administrator's Remand Order dated November 12, 2020. On April 29, 2022, the Board issued a notice of record hearing. Recently (and subsequent to that Notice), it has come to the Board's attention that the Providers have been pursuing the Board's April 15, 2021 denial of expedited judicial review ("EJR") in federal court, notwithstanding the Board's findings that:

1. Pursuant to the District Court's remand, "[t]he Board has been tasked with certain factual and legal development and until that is complete, the Board cannot consider EJR."[3]

2. "[T]he EJR request itself is ***wholly*** underdeveloped and conclusory. For example, it ignores the mandates of the Remand Orders and their effect, if any, on the Board's jurisdiction and authority to consider and issue EJR in this instance."[4]

3. "[T]he briefing schedule is not yet complete and, as a result, the Board has not yet begun considering the parties' comments regarding the relevance of the 2021 IPPS Final Rule, an intervening event, which may or may not eliminate the need for EJR when the requisite factual findings are made and the issues are reviewed in their totality."[5]

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[1] 2015 WL 9582761 (H.C.F.A.).
[2] The remand pertained to 29 group cases. However, following remand, on February 20, 2022, the Providers' representative withdrew the CIRP groups under Case Nos. 09-0025GC and 09-0026GC for Daughters of Charity Health System (now known as Verity Health System). As such, these 2 withdrawn CIRP group cases remain closed, and the attached case listing shows them as cross off. That said, the Board assumes (but is unsure) whether these 2 withdrawn CIRP group cases were similarly withdrawn from the federal litigation discussed herein. In this regard, the Board notes that, while the Providers' representative did not file its November 30, 2022 letter (as discussed *infra*) in the 2 withdrawn cases, the caption for that letter still lists the 2 withdrawn cases.
[3] EJR Denial at 6 (Apr. 15, 2021)
[4] *Id.* (emphasis in original).
[5] *Id.* (with footnote stating: "The EJR Request is conclusory in its application of the new regulatory provisions governing indigent dual-eligible beneficiaries (including qualified Medicare beneficiaries) at 42 C.F.R. § 413.89(e)(2)(iii) and does not cite to them or apply them in any meaningful manner. For example, the EJR Request does not discuss the extent to

It is the Board's understanding that the U.S. Federal District Court for the District of Columbia ("D.C. District Court") dismissed the Providers' litigation in *Mercy Gen'l Hosp. v. Becerra*, No. 21-1397, 2022 WL 17-039188 (D.D.C. Nov. 17, 2022) and the Providers then filed an appeal to the U.S. Court of Appeals for the D.C. Circuit on January 19, 2023 under Case No. 23-5013. Set forth below is the Board's decision to **close** the cases pursuant to 42 C.F.R. § 405.1842(h)(3)(iii).

Board Ruling to Suspend the Record Hearing and Close the Cases:

It has recently come to the Board's attention that the Providers are pursuing the above-captioned cases in the federal court system, currently in litigation before the D.C. Circuit. In this regard, the Board notes that all of the above-captioned cases are group cases for which there may be only "***a single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers."[6] The Providers' representative initially ***obliquely*** notified the Board of this litigation in its March 14, 2022 filing, which was made in response to the Board's February 18, 2022 request for information regarding the appropriateness of the case for a hearing on the record. The Provider's March 14, 2022 response stated that:

1. "the record is complete";
2. "there need not be a live or video hearing"; and
3. "it is the Providers' position that this case is inappropriate for hearing [*sic* live or video hearing], given that the Court remanded this case to the agency for further explanation of the basis for the Administrator's November 15, 2015 decision, and not for additional evidentiary submission or argument, and given that retroactive rulemaking – ***which Providers have appealed to federal court*** – necessarily would apply to the claims for reimbursement at issue."

This *circuitous* reference to the Providers "hav[ing] appealed to federal court" a challenge to the rulemaking failed to confirm that the appeal was actually for the above-captioned cases and failed to provide any information on that appeal (*e.g*., date of filing, court, case number, and status of the case).

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which the 'through no fault of the provider' provisions at 42 C.F.R. § 413.89(e)(2)(iii)(B) may or may not be applicable to the Providers and, thereby, obviate the need for EJR. Indeed, to this point, this regulation (which has not yet been reviewed by the Board) appears to have certain parallels with PRM 15-2 § 1102.1L which remains at issue in the remand. Further, one of the Board's tasks on remand is "to evaluate whether the plaintiffs billed the state for the claims at issue" which, in turn, feeds into the applicability of this regulation. *See* Plaintiff Providers' Brief at 1 (stating "[i]t is likely that some of the outpatient claims at issue were billed, and it is known that some of the inpatient claims at issue were billed, but not processed to the point of receiving a remittance advice.").").

[6] 42 C.F.R. § 405.1837(a)(2) (emphasis added). *See also* 42 U.S.C. § 1395oo(b) (stating: "The provisions of subsection (a) shall apply *to any group of providers* . . . if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, ***but only if*** the matters in controversy involve ***a*** *common* question *of fact or interpretation of law or regulations* and the amount in controversy is, in the aggregate, $50,000 or more." (emphasis added)); 42 U.S.C. § 1395oo(f)(1) (stating in pertinent part: "Any appeal to the Board or action for judicial review by providers which are *under common ownership or control* or which have obtained a hearing under subsection (b) *must be brought by such providers as a group* with respect to any matter involving an issue common to such providers." (emphasis added)).

The Providers did not properly notify the Board of the ongoing litigation until November 30, 2022, through a filing which states, in pertinent part:

> The Providers eagerly await a decision [from the Board] in the above-referenced cases. Moreover, the federal district court who has ruled on litigation regarding these cases has now twice directed the government to act expeditiously on remand. *The Providers* ***intend to file a new court action*** *under the Administrative Procedure Act for agency action unreasonably delayed*. ***Moreover, they are considering appealing the latest court decision granting the Secretary's motion to dismiss, which notice of appeal is due January 17, 2023***. However, the Providers—and probably all parties involved—would much prefer the Board to render a decision on the above-referenced cases rather than having to litigate an unreasonable delay case and/or an appeal of the most recent federal court decision. Therefore, the Providers write the Board in hopes of real progress rather than engaging in continued start-and-stop litigation that drains the resources of the parties, the government, and judicial resources. *To that end, the Providers respectfully request a Board decision by January 10, 2023, after which date they will need to explore additional judicial options*.
>
> ****
>
> The Providers—after seeking [EJR] and receiving in response what was in their view was not the statutorily-required determination as to their request for EJR—filed a new action in court on May 21, 2021 challenging the new regulations and including related challenges.
>
> The Secretary filed a motion to dismiss this latest court case and, on November 17, 2022, the Court granted the Secretary's motion to dismiss. In doing so, the Court cautioned:
>
> > . . . . The remand order was issued on October 17, 2019, which now was over three years ago. While the Court does not find that the Secretary has failed to comply with the remand order at this time, the Court continues to urge the Secretary to expeditiously resolve this matter. The plaintiff's compliance with the Board's requests will hopefully assist in accomplishing this objective.
>
> Mem. Op. *Mercy Gen. Hosp. v. Becerra*, 1:21-cv-1397-RBW (Nov. 17, 2022), at 23 n.12 (ECF No. 32).

> In conclusion, the Providers have complied with the Board's requests and they eagerly await a decision. The Providers' Notice of Appeal of the District Court's decision is due January 17, 2023, and they may file lawsuit for agency action unreasonably delayed at any time. The court has urged expeditious action. The Providers respectfully request a Board decision by January 10, 2023.

The Providers are mistaken in their belief that their appeal and pending litigation has no impact or effect on the Board proceedings in the above-captioned cases, including the on-the-record hearing that the Board has been conducting consistent with the Board's April 15, 2021 determination denying EJR and the Board's April 29, 2022 Notice of Record Hearing. 42 C.F.R. § 405.1842(h) provides the following instruction regarding the effect of litigation on Board proceedings when the litigation pertains to a previously-filed EJR request and/or Board denial of that EJR request:

> (h) ***Effect of*** *final EJR decisions and* ***lawsuits*** ***on further Board proceedings*** —. . . .
>
> 2) *Final decisions denying EJR*. If the final decision:
>
> (i) Of the Board denies EJR solely on the basis that the Board determines it has the authority to decide the legal question relevant to the specific matter at issue, the Board must conduct further proceedings on the legal question and issue a decision on the matter at issue in accordance with this subpart.
>
> **Exception**: If the provider(s) file(s) a lawsuit pertaining to the legal question, and for a period that is covered by the Board's decision denying EJR, **the Board may not conduct any further proceedings under this subpart on the legal question or the matter at issue before the lawsuit is finally resolved**.
>
> (ii) Of the Board (or the Administrator) denies EJR on the basis that the Board lacks jurisdiction over the specific matter at issue, the Board (or the Administrator) must, as applicable, dismiss the specific matter at issue from the appeal, or dismiss the appeal entirely if there are no other matters at issue that are within the Board's jurisdiction and can be fully decided by the Board. If only the specific matter(s) is dismissed from the appeal, judicial review may be had only after a final decision on the appeal is made by the Board or Administrator, as applicable (as described in §§ 405.1840(d) and 405.1877(a) of this subpart). If the Board or the Administrator, as applicable, dismisses the appeal entirely, the decision is subject to judicial review under § 405.1877(a) of this subpart.

> (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.
>
> (ii) If the lawsuit is filed after a final EJR decision by the Board or the Administrator, as applicable (as described in §§ 405.1842(g)(1) and 405.1875(e)(4) of this subpart), on the legal question, the Board must carry out the applicable provisions of paragraphs (h)(1) and (h)(2) of this section in any pending Board appeal on the specific matter at issue.
>
> (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**.[7]

Accordingly, no further proceedings were to occur in these cases until the litigation initiated on May 15, 2019 had been "resolved." In this regard, the Providers' representative apparently waited roughly 10 months before it included an oblique reference to an appeal in federal court. However, the Providers' representative failed to notify the Board or the opposing party (*i.e*., the Medicare Contractor) *that the litigation was an appeal of the above-captioned cases*, and failed to disclose any information about that litigation such as the name of the court, the case number, and the date the litigation was filed. The failure to properly and timely notify the Board and the opposing party wastes administrative resources. Specifically, the malfeasance of the Providers' representative prevented the Board and the opposing party from making independent assessments of the Providers' litigation; specifically, its effect on the Board proceedings and compliance with 42 C.F.R. § 405.1842(h)(3)(iii).[8] Accordingly, the ***belated*** November 30, 2022 notification to the Board highlights that the Providers' litigation has not, in fact, been "resolved" but is, in fact, ongoing.[9]

Further, the Board takes administrative notice that the Providers did file an appeal with the D.C. Circuit and have raised the following questions in that appeal. These questions (in particular Question #6) confirm that the Providers' ongoing federal litigation continues to have direct bearing on the Board proceedings in the above-captioned cases:

> 1. Whether the [Board] failed to make a statutorily required determination in the statutorily required time period as to Plaintiff-

[7] (Bold and underline emphasis added and italics in original.)
[8] *See also supra* note 2.
[9] Informing the Board that it must issue a decision within a 41-day period (which includes multiple federal holidays), or else the Providers intend to continue with their litigation is not resolution of the litigation. The Board is an independent administrative review board and is not a party to the litigation pending in the federal court system. *See also supra* note 2.

> Appellants' request for expedited judicial review, thus entitling Plaintiff-Appellants to expedited judicial review.
>
> 2. Whether the phrase "relevant to" in 42 U.S.C. § 1395oo(f)(1) provides a loophole that enables the Board—generally or in specific cases—to deprive providers of their statutory right to judicial review despite the Board failing to make statutorily-required determinations within the statutorily-mandated time period.
>
> 3. *Whether the retroactive rulemaking challenged by the Plaintiff-Appellants below is clearly relevant to the matter at hand* such that a loophole created by the "relevant to" statutory language—if any such loophole exists (Plaintiff-Appellants do not believe it does)—is inapplicable to Plaintiff-Appellants' request for expedited judicial review at issue in this case.
>
> 4. Whether Plaintiff-Appellants are entitled to judicial review over their legal challenge to retroactive rulemaking that has not yet been applied to them.
>
> 5. Whether a Board determination on a provider's request for expedited judicial review is subject to judicial review.
>
> 6. ***Whether Defendant-Appellee exceeded or failed to comply with the scope of the district court's remand order in prior related proceedings***.[10]

In summary, there has been no ***final*** EJR decision (or other final decision) closing these group appeals. Rather, the Board has been conducting a record hearing on the above-captioned cases consistent with the Administrator's Remand Order, the Board's April 15, 2021 determination denying EJR, and the Board's April 29, 2022 Notice of Record Hearing. As part of those on-the-record proceedings, it has recently come to the Board's attention that, ***for the above-captioned cases***, the Providers are pursuing federal litigation before the Board has issued a final decision in those cases (*e.g.*, a final decision on the merits or a final EJR decision). Based on this additional information, and the findings made above, 42 C.F.R. § 405.1842(h)(iii) is applicable and "the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved." Therefore, the Board hereby: (1) suspends the Record Hearing for the above-captioned cases; and (2) closes and removes the above-captioned cases from the Board's docket. Consequently, no further proceedings on the Record Hearing for the above-captioned cases will occur, except: (1) upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2) (or other similar authority); and (2) as appropriate and consistent with the instructions/order accompanying such remand.

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[10] *Mercy Gen. Hosp. v. Becerra*, No. 23-5013, Statement of Issues To be Raised at 2 (D.C. Cir. Feb. 14, 2023) (emphasis added).

Admonishment of the Providers' Representative:

The Board reminds the Providers' representative of its obligation, under Board Rule 1.3, to communicate early and in good faith:

> **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.[11]

Here, the Providers' representative waited roughly 10 months before it included an *oblique* reference to an unresolved appeal in federal court that the Providers intended to pursue further. However, that vague reference failed to specifically notify the Board, or the opposing party, *that the litigation was an appeal of the above-captioned cases* and did not provide any information about that litigation (*e.g.* the name of the court, the case number, and the date the litigation was filed). The Providers' representative's failure to properly and timely notify the Board and the opposing party wastes administrative resources and prevented the Board and the opposing party from making independent assessments of the Providers' litigation (and its effect) on the Board proceedings and compliance with 42 C.F.R. § 405.1842(h)(3)(iii). Accordingly, the Board ***admonishes*** the Providers' representative for its failure to comply with Board Rule 1.3 by ***properly*** and ***timely*** apprising the Board of the litigation it is pursuing in relation to these cases.

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For the Board:

5/17/2023

X Clayton J. Nix

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

Enclosure: Attachment A – Listing of the 27 Cases Remaining in the Original Remand (*see* supra note 2)

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Bernie Talbert, Federal Specialized Services
Jacqueline Vaughn, CMS OAA

[11] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21207
410-786-2671

Via Electronic Delivery

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RE: ***Board Determination on Disposition of Fully Formed Single Provider CIRP Group***
CHS CY 2009 Inclusion of Medicare HMO Days in GME Calculation CIRP Group
Case Number: 14-3709GC

Dear Mr. Hettich and Mr. Lamprecht:

On April 10, 2023, the Provider Reimbursement Review Board (the "Board") issued a Request for Information ("RFI") requesting comments regarding the disposition of the subject common issue related party ("CIRP") group because it noted an impediment to the Board's jurisdiction. To date, King & Spalding, LLP ("K & S") has not responded to the Board's RFI. A summary of the pertinent facts and the Board's own motion determination are set forth below.

Pertinent Facts:

On March 31, 2023, K & S designated the subject group appeal to be fully formed with only a single participant, Lutheran Hospital of Indiana ("Lutheran"/Provider Number 15-0017).

On April 10, 2023, the Board issued an RFI in accordance with Board Rule 18. In it, the Board addressed the fact that the subject CIRP could not proceed with only a single participant. The Board explained that its preference in this situation would normally be to consolidate the single participant group into an expanded earlier or later year CIRP for the same organization and issue. Unfortunately, after a search of its database, the Board was unable to locate any pending appeals for the Inclusion of Medicare HMO Days in GME Calculation for earlier or later years for the CHS organization.[1] Therefore the Board proposed to create a new individual case for the sole provider, Lutheran, for CY 2009 consistent with Board Rule 18 in order to transfer the "Inclusion of Medicare HMO Days in GME Calculation" issue from Case No. 14-3709GC to the new individual case. The Board advised that following the transfer, Case No. 14-3709GC would be closed as there would be no remaining participants.

Board Determination:

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

[1] The Board noted the two earlier year CIRP groups for CY 2007 and 2008 for the Inclusion of Medicare HMO Days in GME Calculation issue had been previously consolidated under Case No. 14-2096GC. Case No. 14-2096GC was subsequently withdrawn on February 20, 2023.

Board Rule 12.5 indicates that "[p]roviders in a group appeal must have final determinations for their cost reporting periods that end with the same calendar year."[2] Although a provider can request to include more than one calendar year to meet the minimum number of providers or the $50,000 amount in controversy requirements, Rule 12.6.1 stipulates that a "CIRP group may be initiated by a single provider under common ownership or control, **but at least two different providers must be in the group upon full formation**."[3] (Emphasis added) Further 42 C.F.R. § 405.1837(b) requires that a group appeal have two or more providers.

Board Rule 18 states that: "After opportunity for comment by the parties, the Board may require a group to restructure appeals either to comply with the law or for judicial economy." In its April 10, 2023 RFI, the Board provided K & S the opportunity to comment on its proposal to transfer the group issue for the sole provider back to a new individual appeal that would be created for Lutheran for CY 2009.[4] The Board advised that the transfer of the Provider to an individual appeal would result in the closure of the CIRP group, Case No. 14-3709GC.

As noted, K & S failed to respond to the Board's RFI by the deadline. Accordingly, this letter serves as notice to the Parties that the Board is proceeding with its intended actions and is:

1. Transferring the "Inclusion of Medicare HMO Days in the GME Calculation" issue from Case No. 14-3709GC to a new individual appeal that is being created for Lutheran. (The Parties will receive an Acknowledgement and Critical Due Dates for the new case under separate cover.);
2. Closing Case No. 14-3709GC as there are no remaining participants.

The Board reprimands K & S for its failure to follow Board Rules in that it did not, on its own initiative, request the Board restructure the group once it realized the group was fully formed with only a single provider (*i.e.* request an expansion of another group in order to consolidate or, in the alternative, transfer the provider back to an individual appeal). Finally, the Board admonishes K & S for its failure to file comments by the deadline in accordance with the Board's RFI.

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

For the Board:

5/18/2023

X Kevin D. Smith, CPA

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

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

[2] Board Rules (Aug. 29, 2018, revised Nov. 1, 2021).
[3] Id.
[4] The Representative's comments were due to the Board by April 25, 2023.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
East Georgia Regional Medical Center (Prov. No. 11-0075)
FYE 09/30/2016
Case No. 19-1855

Dear Messrs. Ravindran and Lamprecht,

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

Background:

A. ***Procedural History for Case No. 19-1855***

On October 5, 2018, the Medicare Contractor ("MAC") issued to the Provider the Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016 ("FY 2016").

On April 8, 2019, the Board received the Provider's individual appeal request for the FY 2016 NPR. The initial Individual Appeal Request contained nine (9) issues:

1. DSH SSI Percentage (Provider Specific)
2. DSH SSI Percentage[1]
3. DSH Medicaid Fraction Dual Eligible Days[2]
4. DSH SSI Fraction Medicare Managed Care Part C Days[3]
5. DSH SSI Fraction Dual Eligible Days[4]
6. DSH Medicaid Eligible Days
7. Uncompensated Care (UCC) Distribution Pool[5]
8. DSH Medicaid Fraction Medicare Managed Care Part C Days[6]
9. 2 Midnight Census IPPS Payment Reduction[7]

[1] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0197GC.
[3] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0175GC.
[4] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0198GC.
[5] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0177GC.
[6] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0159GC.
[7] On November 15, 2019, this issue was transferred to PRRB Case No. 19-0185GC.

The Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1) since the Provider is owed by Community Health Systems ("CHS"). Accordingly, on November 15, 2019, the Provider transferred Issues 3, 4, 5, 7, 8, and 9 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 6 (the DSH – Medicaid Eligible Days issue).

On December 2, 2019, the Provider filed its preliminary position paper. Similarly, on March 25, 2020, the MAC filed its preliminary position paper.

On November 14, 2022, the MAC filed a Jurisdictional Challenge requesting that the Board dismiss Issues 1 and 6. On December 14, 2022, the Provider timely filed its response to that Challenge. On December 28, 2022, the MAC filed its reply to the Provider's filing.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-0173GC

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.[8]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH SSI Percentage – to the common issue related party ("CIRP") group under Case No. 19-0173GC on November 15, 2019. The group issue in Case No. 19-0713GC 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

[8] Issue Statement at 1 (Apr. 8, 2019).

of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?

Statement of the Legal Basis

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

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

1. Availability of MEDPAR and SSA records,
2. Failure to adhere to required notice and comment rulemaking procedures,
3. Fundamental problems in the SSI percentage calculation,
4. Not in agreement with provider's records,
5. Paid days vs. Eligible Days, and
6. Covered days vs. Total days.[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $40,000.

On December 2, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Calculation of the SSI Percentage

The Provider contends that the MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww (d)(5)(F)(i). The Provider contends that the SSI percentages calculated by 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:

Provider Specific

The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients

[9] Group Issue Statement, Case No. 19-0173GC.

> that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Georgia and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Georgia 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/HCFAJOIS, 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.[10]

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DHS 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 of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not

[10] Provider's Preliminary Position Paper at 8-9 (Dec. 2, 2019).

> exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.[11]

In addition, the MAC argues the DSH SSI% - Provider Specific issue and the DSH SSI Percentage - Systemic issue are considered the same issue by the Board.[12]

Issue 3 – Medicaid Eligible Days

The MAC argued that the Provider abandoned the DSH – Medicaid Eligible Days issue because they have not submitted a list of the Medicaid eligible days at issue in this case and have not fully addressed the issue in their preliminary position paper in violation of Board Rule 25.3. The MAC notes that it specifically requested this listing from the Provider on 2 different dates (June 5, 2019 and September 8, 2022); however, the Provider never responded to the request. Specifically, the MAC makes the following arguments:

> The MAC contends that the Provider was in violation of Board Rule 25.3 when they failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed. . .
>
> Within their preliminary position paper, the Provider makes the broad allegation, "[t]he Provider contends that the total number of days reflected in its' . . . cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.
>
> ****
>
> Notably, the Providers have not included a list of additional Medicaid eligible days with their preliminary position papers or under separate cover, which were requested twice. 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.[13]

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

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[11] Jurisdictional Challenge #1 at 7 (June 25, 2019).
[12] *Id*. at 6.
[13] Jurisdictional Challenge #2 at 4, 6 (Nov. 14, 2022) (footnotes omitted).

2. Provider's Jurisdictional Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider's December 14, 2022 response did not address this portion of the MAC's Jurisdictional Challenge.

Issue 5 – Medicaid Eligible Days

The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[14] The Provider goes on to argue that

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment.[15]

The Provider goes on to assert that "[c]oncurrent with this letter . . . the Provider[is] sending to the MAC the listing of additional Medicaid eligible days" and that "[a] redacted version of this listing is being posted to the Board's portal." Accordingly, the Providers assert that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[16] However, the Board notes that the Provider did not file the promised redacted listing of Medicaid eligible days or even identify how many Medicaid eligible days are actually in dispute.

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

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[14] Jurisdictional Response at 1 (Dec. 14, 2022).
[15] *Id*. at 2.
[16] *Id*.

3. MAC's Reply to Provider's Jurisdictional Response

On December 28, 2022, the MAC filed a reply to the Provider's Jurisdictional Response to make the following additional arguments supporting the dismissal of Issue 6:

- "The Providers' argument that Rule 27.1 somehow permits the filing of incomplete preliminary position papers for these appeals is simply incorrect. None of the appeals were filed prior to the effective date of PRRB Rules Version 2.0. Both Versions 2.0 and 3.1 of the PRRB Rules require just the opposite. . . . The PRRB Rules make clear that providers are to file with the Board complete preliminary position papers, including exhibits, and final position papers are optional for appeals filed on or after the August 29, 2018 effective date of Version 2.0. The Providers' understanding and expectation that the preliminary position papers could be filed without fully developed positions and exhibits is clearly erroneous and without merit."

- "There is nothing in the record to even suggest that the Providers were relying on Alert 19 or were otherwise prevented from following PRRB Rules due to COVID. To raise the recent raise in children respiratory illness cases as an extenuating circumstance for submitting preliminary position papers which fail to follow PRRB Rules is brazen, especially given that preliminary papers for the appeals were submitted between ten (10) to 42 months ago."

- In response to the Provider's claim that it has cured the defect, the MAC contends that "[t]he Providers' Response offers no regulatory or PRRB Rule allowing for curing its defect of failing to follow PRRB Rules applying the filing of preliminary position papers."

Accordingly the MAC restates its request that the Board dismiss Issue 1 from the appeal.

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was appealed in PRRB Case No. 19-0173GC.

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."[17] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[18] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 19-0173GC 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. 19-0173GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6,[20] the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 19-0173GC 1332GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-0173GC.

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

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. 19-0173GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from [Georgia] State records" but fails to explain what that means, what the basis for the alleged fact is,[22] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

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

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

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

Finally, the Board notes that the Provider failed to respond to the MAC's Jurisdictional Challenge that Issue 1 is a prohibited duplicate issue and, per Board Rule 44.4.3, the Board must make a determination on the record before it.

Accordingly, the Board finds that, *based on the record before it,* the remaining issue in the instant appeal and the group issue from Group Case 19-0173GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH – SSI 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 from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. Medicaid Eligible Days

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

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[23] Last accessed February 24, 2023.
[24] Emphasis added.

Statement of the Issue

Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.

Statement of the Legal Basis

The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.

The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[25]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[26] The Provider later argued that there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[27]

Board Rule 7.3.2 (Aug. 2018) states:

No Access to Data

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

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

[25] Individual Appeal Request, Issue 5.
[26] Provider's Preliminary Position Paper at 8 (Dec. 2, 2019).
[27] Jurisdictional Response at 1.

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. Moreover, the Provider has failed to state the precise number of Medicaid eligible days at issue but rather included the same "*estimated* impact"[28] calculation that it included with the appeal request. In its response to the Jurisdictional Challenge, the Provider is belatedly arguing that, "at this time," there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor. However, the response filed pertained to many cases involving multiple states. As a result, it is unclear whether the allegation even pertains to Georgia (the state in question here) and the Provider fails to state when that change occurred and how it otherwise prevented it from obtaining the listing to include with its preliminary position paper 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.[29]

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*.[30]

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:

> 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.

---

[28] (Emphasis added.)
[29] *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.
[30] (Emphasis added).

Similarly, with regard to position papers,[31] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[32] 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.[33]

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.

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

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

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[34] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. *Based on the record before the Board*, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The Provider's belated generic assertion in its December 14, 2022 filing that "practical impediments are preventing [it] from obtaining the necessary support" due to "the eligibility matching being unavailable at this time due to a change in the State's matching vendor changes"34 is wholly inadequate because:

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

2. Regardless, the statement fails to meet the requirements of Board Rule 25.2.2 since it did not describe its efforts to obtain the unavailable/missing documentation and when it would become available. Indeed, the response filed by the representative covered multiple providers across different states and it is unclear whether the generic references to "the State" was even relevant to this particular Provider and the state in which it is located.

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, contrary to the Provider's assertion, 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

[34] (Emphasis added).

issue closed more than 6 ½ years ago.[35] Similarly, the Provider's reference to the COVID-19 pandemic has no relevance since the Provider's preliminary position paper was filed in 2019 well before the outbreak of the pandemic and the Board's issuance of Alert 19 and the Provider has failed to explain how its *generic* reference to the pandemic otherwise relates to its failure to comply with Board Rules and regulations and its development of the Medicaid eligible days issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[36] The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative[37] as well as cases involving CHS providers.[38] Notwithstanding, QRS and 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 SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC 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. 19-1855 and removes it from the Board's docket.

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

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[35] Note, the Board is *not* ruling that, had the provider done so, it would have accepted the listing at this late date. This situation is not before the Board and, as such, is not part of this ruling.

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

[37] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by Board letter dated 5/5/2022); Case No. 16-2521 (by Board letter dated 5/5/2022); Case No. 16-0054 (by Board letter dated 5/5/2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (by Board letter dated 9/30/2022). Moreover, in Case Nos. 13-3022, 13-3211, 14-2506, and 14-4313, the Board's attention to the filing deficiency was brought to the Board's attention via a motion to dismiss filed by the Medicare Contractor in its position paper (on December 10, 2020, December 11, 2020, March 12, 2021, March 12, 2021 respectively).

[38] 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. 22-0076 (dismissed by Board letter dated Dec. 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. 22-0376 (dismissed by Board letter dated February 22, 2023 based on a MAC December 14, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

Board Members Participating:

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

For the Board:

5/18/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

L. Ryan Hales
Quorum Health
1573 Mallory Ln., Ste. 100
Brentwood, TN 37027

RE: ***Notice of Dismissal of Issue***
Fannin Regional Hospital (Prov. No. 11-0189)
FYE 12/31/2013
Case No. 16-1828

Dear Mr. Hales:

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

Background

The Board received Fannin Regional Hospital's ("Provider's") Individual Appeal Request on June 13, 2016. The request is appealing a Notice of Program Reimbursement ("NPR") dated December 9, 2015.[1] The total amount in controversy listed on the appeal request is $39,000. The appeal request contained the following two disproportionate share hospital ("DSH") issues:

1. DSH Payment/Supplemental Security Income Percentage (Provider Specific); and
2. DSH Payment – Medicaid Eligible Days

On February 22, 2018, the Provider withdrew Issue 1.

On March 2, 2023, the Medicare Contractor filed a Jurisdictional Challenge over the Medicaid Eligible Days issue arguing the Provider failed to file a complete Preliminary Position Paper with supporting documentation as required by the Board Rules.

Positions of the Parties:

On March 2, 2023, the Medicare Contractor filed a Jurisdictional Challenge over the Medicaid Eligible Days issue on March 2, 2023 arguing that the issue should be dismissed for failure to

[1] A hearing request must be received no later than 180 days after receipt of the relevant final determination. 42 U.S.C. § 1395oo(a)(3); 42 C.F.R. § 405.1835(a)(3). Receipt is presumed to be five days after the date of issuance of the NPR. Board Rule 4.3 (2015); 42 C.F.R. § 405.1801(a)(1)(iii). The 185th day following the Provider's NPR was June 11, 2013, which was a Saturday. Since the designated due date fell on a Saturday, the deadline was the next business day. 42 C.F.R. § 405.1801(d)(3) (2015). The Provider's appeal was timely received by the Board on Monday, June 13, 2016.

provide an eligibility listing of the additional days being claimed on appeal. It outlines the Board's Rules which require a Provider to submit supporting documentation with its preliminary position paper or otherwise explain why it is unavailable, and what steps are being taken to obtain it. In this case, the Provider did not provide that listing with the preliminary position paper; but rather promised that a listing would be sent under separate cover. The Medicare Contractor requests the Board dismiss the Medicaid Eligible Days issue because the Provider did not provide any documentation to support its claim for additional days, nor did it respond to multiple requests from the Medicare Contractor to submit the required documentation.[2] As set forth in Exhibit C-1, the Medicare Contractor asserts that it submitted three separate requests to the Provider on August 17, 2016, January 20, 2017, and November 20, 2018 asking for the Medicaid eligible days listing; however, the Provider failed to respond and has not submitted a listing or filed one with the Board.

The Provider has not filed a response to the March 2, 2023 Jurisdictional Challenge within the 30-day period specified in Board Rule 44.4.3.[3] Specifically, Board Rule 44.4.3 states:

> Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

Background on Position Paper Requirements and Failure to Comply:

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*.[4]

[2] Medicare Administrative Contractor's Jurisdictional Challenge, 4 (Mar. 2, 2023); Ex. C-1.
[3] Board Rule 44.3 (Nov. 2021) requires responses to be filed within thirty days of service. A response to the Medicare Contractor's Jurisdictional Challenge filed on March 2, 2023 was due no later than Monday, April 3, 2023.
[4] (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) (July 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,[5] Board Rule 25.2(A) (2015) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[6] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Consistent with that regulation, Board Rule 25.2(B) (2015) also 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.[7]

With regard to a Provider's Preliminary Position Paper, Board Rule 25.1(A) (2015) also requires:

1. For each[8] issue, state the material facts that support your claim.
2. Identify the controlling authority . . . supporting your position.
3. Provider a conclusion applying the material facts to the controlling authorities.

As explained in the Commentary to Rule 23.3 (2015), "the Board expects preliminary position papers to be *fully developed* and include ***all*** *available* documentation necessary to give the parties a thorough understanding of their opponent's positions."[9]

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.

---

[5] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* Board Rule 27.2 (2021).
[6] (Emphasis added.)
[7] (Emphasis added.)
[8] (Emphasis in original.)
[9] (Emphasis added.)

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

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

Failure to comply with the Board's rules can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. ***The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules*** and orders or for inappropriate conduct during proceedings in the appeal.
> (b) ***If a provider fails to meet*** a filing deadline or ***other requirement*** established by the Board ***in a rule*** or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.[10]

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

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

Decision of the Board

As described above, the regulations and Board Rules require the parties to file a position papers that set forth the relevant facts and arguments regarding the merits of their claims and provide all

[10] (Emphasis added).

available supporting documentation and exhibits. Board Rule 25.2(A) (2015) requires that, as part of the position paper filing, "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[11] Further, if there are any documents not available for the position paper filing, then Board Rule 25.2(B) requires the Provider to identify those documents, explain why they are unavailable, describe the efforts to obtain them, and describe when they are expected to be available.

The Board concurs with the Medicare Contractor that the Provider is required to identify the Medicaid eligible days in dispute and to provide documentation to support the additional Medicaid Eligible days to which it alleges it may be entitled. Here, the June 13, 2016 appeal request gave an "Estimate Impact" of $32,843 for the Medicaid eligible days issue. However, the Provider failed to explain on how that amount was derived and failed to specify how many days are in dispute (whether actual or estimated). The Board notes that, in this regard, 42 C.F.R. § 405.1835(b) (2016) states in pertinent part:

> (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 V 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.
>
> ****
>
> (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

[11] (Emphasis added.)

> 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.

The Provider filed its preliminary position paper on February 27, 2017 and included an exhibit for the listing of Medicaid eligible days in dispute. However, the Provider did not include that listing but rather suggested its release was imminent by promising that it was being sent under separate cover.[12]

Based on the record before the Board, and noting that the Provider has been provided sufficient opportunity to rebut the Medicare Contractor's claims but failed to respond,[13] 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. Moreover, the Provider has not cured this defect by responding to the Medicare Contractor's multiple requests or the Medicare Contractor's motion to dismiss (even though a response was due within 30 days per Board Rule 44.4.3).

The Board also finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.A and 25.2.B (2015) related to the submission of the relevant facts supporting the merits of this issue and the documentary evidence required to support its claims or describe why said evidence is unavailable. The Board further notes that: (1) the fiscal year at issue in the appeal ended more than 9 years ago on December 31, 2013; (2) this appeal has been pending for almost 7 years; and (3) notwithstanding this passage of time, the Provider has failed to provide the Medicaid eligible days listing at this late date as promised in its preliminary position paper (now filed over 6 years ago) and has failed respond to the Medicare Contractor's requests for a Medicaid Eligible days listing and the Medicare Contractor's March 2, 2023 motion to dismiss. Clearly, under 42 C.F.R. §§ 412.106(b)(iii) the Provider has the burden of proof for each Medicaid eligible day in dispute but the Provider has failed to identify even a single day in dispute. Based on the above, pursuant to 42 C.F.R. § 405.1868(a)-(b), the Board is exercising its discretion to dismiss the Medicaid Eligible Days Issue from this case for failure to comply with the requirements established by the Board rules and regulations and for the Provider's abandonment of the Medicaid eligible days issue as demonstrated by the Provider's failure to respond to the Medicare Contractor's filings and requests. Finally the Board takes

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[12] The Provider's preliminary position paper includes only the cover pate and exhibit list which shows an Exhibit P-1 for Medicaid eligible days listing. However, in its Jurisdictional Challenge, the Medicare Contractor documents that the Provider failed to include that listing with its preliminary position paper filing but rather promised to send it under separate cover. Accordingly, the Provider's filing was misleading and inaccurate as no such listing was ever provided to the Medicare Contractors. Similarly, the Medicare Contractor's jurisdictional challenge lists the 3 different times it requested the listing from the Provider. Finally, the Medicare Contractor's preliminary position paper includes Exhibit I-3 a description of its request for Medicaid eligible day information and as Exhibit I-2 a copy of its jurisdictional challenge. Significantly, the Provider has filed no response to the Medicare Contractor's dismissal request whether within the 30-day period specified in 44.4.3 or afterwards.

[13] *See* Board Rule 44.4.3 (2021).

administrative notice that it has made similar dismissals in other cases involving Quorum Health providers.[14]

Conclusion:

Based on the foregoing, the Board hereby dismisses the Medicaid Eligible Days issue from Case No. 16-1828. Since this is the sole remaining issue in the case, the Board hereby closes it and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

5/22/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

[14] Examples include, but are not limited to: Case No. 17-2247 (Board dismissal letter dated Aug. 22, 2022 based on a June 16, 2022 Medicare contractor motion to dismiss the Medicaid eligible days issue for failing to provide such listing with the position paper filing and failing respond to multiple Medicare contractor requests); Case No. 19-2771 (Board dismissal letter May 1, 2023 based on a February 28, 2023 Medicare contractor motion to dismiss the Medicaid eligible days issue for failing to provide such listing with the position paper filing and failing to respond to multiple Medicare contractor requests).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Merit Health River Region (Provider Number: 25-0031)
FYE: 06/30/2014
Case Number: 17-0380

Dear Messrs. Summar and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-0380. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 17-0380

On May 9, 2016, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2014. On November 3, 2016, 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[1]

The DSH Payment/SSI Percentage (Provider Specific) remains pending in the appeal.

The Provider is subject to the mandatory rules governing common issue related party ("CIRP") groups at 42 C.F.R. § 405.1837(b)(1) since the Provider is owned by Community Health Systems. Accordingly, prior to the filing of the individual appeal, in November, 2016, the Provider was directly added to Case No. 16-1192GC, Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group on August 24, 2016.

[1] This issue was withdrawn on April 6, 2023.

B. Description of Issue 1 in the Individual Appeal Request and the Provider's Participation in Case No. 16-1192GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider 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).[2]

In PRRB Group Case No. 16-1192GC, Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group, which is being appealed from the same NPR as the instant appeal for the same fiscal year end, the Providers described their DSH/SSI Percentage (Systemic Errors) issue as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. The issue statement reads, in part:

> The failure of the Fiscal Intermediary and [CMS] to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (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 Disproportionate Share Hospital (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 a 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 DSH purposes . . .

[2] Issue Statement at 1 (Nov. 3, 2016).

> 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.[3]

On April 10, 2023, the Provider submitted 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.
>
> 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-2).

[3] Group Issue Statement in PRRB Case No. 16-1192GC (Mar. 1, 2016).

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 a portion of 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). 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.[4]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[5]

Provider's Jurisdictional Response

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[6] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[7]

Finally, the Provider contends the Provider Specific issue is appealable "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 2014, resulting from its understated SSI percentage due to errors of omission and commission."[8]

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[4] Jurisdictional Challenge at 3 (Apr. 23, 2018).
[5] *Id*. at 2.
[6] Jurisdictional Response at 1 (May 22, 2018).
[7] *Id*. at 2.
[8] *Id*.

Board Analysis and Decision:

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

A. DSH – SSI Percentage (Provider Specific)

The 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 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*[9] into its appeal.

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage— concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] 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)."[11] 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."[12]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in Group Case No. 16-1192GC 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). The Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue directly added to Case No. 16-1192GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

[9] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*

PRRB Rule 4.5[13], 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 16-1192GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] 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. 16-1192GC.

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. 16-1192GC, 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 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

[13] PRRB Rules v. 1.3 (July 2015).
[14] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

> pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

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

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-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 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

[15] Last accessed February 24, 2023.
[16] Emphasis added.

> 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]

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 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.

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In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Group Case No. 16-1192GC 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. 17-0380 and removes it from the Board's docket.

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

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For the Board:

5/30/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

[17] (Emphasis added).