DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Indian River Memorial Hospital (Provider Number: 10-0105)
FYE: 09/30/2014
Case Number: 17-1998

Dear Messrs. Ravindran and Pike:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-1998 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. 17-1998*

Indian River Memorial Hospital ("Provider") appealed a Notice of Program Reimbursement ("NPR") dated February 9, 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 (Systemic Errors)
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
4. DSH Payment – SSI Fraction/Dual Eligible Days
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days
8. Outlier Payments – Fixed Loss Threshold

Issues 2-4 and 6-7 were transferred to group cases on March 22, 2018. The Medicare Contractor filed a Jurisdictional Challenge dated April 24, 2016, regarding two of the remaining issues, i.e., the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment - Medicaid

eligible days issue. On May 22, 2018, the Provider filed a response to the Jurisdictional Challenge.

On May 26, 2023, the PRRB requested that the Medicare Contractor indicate whether a decision was still needed on the Medicaid eligible days issue. On May 30, 2023, the Medicare Contractor responded that the jurisdictional challenge to Medicaid eligible days issue is no longer relevant and a Board decision is no longer needed on that particular issue. However, the Medicare Contractor clarified that it continues to challenge the DSH Payment – SSI Percentage (Provider Specific) issue.

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 the DSH Payment – SSI Percentage (Provider Specific) issue as follows:

> [T]he MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[1]

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.[2] The Provider further contends that the SSI percentage issued by CMS and the subsequent adjustment to the Provider's cost report by the Medicare Contractor are both flawed, and that 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.[3]

Finally, the Provider "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period," citing 42 U.S.C. § 1395(d)(5)(F)(i). The amount in controversy was listed as $107,909.[4]

In the SSI percentage issue in group case 17-0863G, to which this issue was transferred, the Providers assert in their group issue statement as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in

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

> accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi). The Providers contend that the SSI percentages calculated by the [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Providers also contend that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet 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 the [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare statute.
>
> The Providers . . . also seek[] 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[5]

On April 25, 2023, the Provider filed its final position paper in the instant case. The following is the Provider's ***complete*** position on Issue 1, DSH Payment – SSI Percentage (Provider Specific) issue, set forth therein:

[5] Provider's Group Appeal Request (Case No. 17-0863G), Group Issue Statement (Jan. 23, 2017).

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 percentage 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 these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[6]

MAC's Contentions

The MAC first notes that in Issue 1, the Provider contends that the MAC used the incorrect SSI percentage in processing its DSH payment, and in Issue 2, the Provider contends that the Secretary improperly calculated its SSI percentage. The MAC argues that the Provider is making the same argument, as the MAC is required to use the SSI ratio provided by CMS and the SSI ratio is the underlying dispute in both Issues 1 and 2. Issue 2 has been transferred to group case 17-0863G, and thus the MAC asserts that the Provider has attempted to appeal the

[6] Provider's Final Position Paper at 10-11 (Apr. 25, 2023).

same issue in more than one appeal at the same time, which is prohibited under Board Rule 4.5, which prohibits duplicate filings.[7] Therefore, Issue 1 should be dismissed as it is duplicative of Issue 2, which has been transferred to case number 17-0863G.

Provider's Response

In response, the Provider asserts that the two SSI issues are separate and distinct, and represent different components of the SSI issue. The Provider cites to Board Rule 8.1 to supports its position that each contested component must be appealed as a separate issue and described as narrowly as possible. The SSI Systemic issue addresses the various errors discussed in *Baystate,* whereas the SSI Provider Specific issue addresses the errors of omission and commission that do not fit into the "systemic errors" category, noting it has reason to believe the SSI fractions were understated due to the number of days included in the SSI ratio.[8]

Board Analysis and Decision

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

A. DSH SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has 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 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—in the present appeal concerns "[w]hether 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

[7] MAC's Jurisdictional Challenge (Apr. 24, 2018).
[8] Provider's Response to Jurisdictional Challenge (May 22, 2018).
[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.

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 Payment/SSI Systemic issue, now 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 Board Rule 4.5,[13] the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulatory 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 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.[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. 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.

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[11] *Id.*
[12] *Id.*
[13] Board 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).

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.[15]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows:

[15] Last accessed April 14, 2023.

> "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]

While the Provider indicated that the data made available "lacks all data records necessary to fully identify all patients properly includable in the SSI fraction," the Provider does not specifically 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.

With regard to the third aspect of Issue 1, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)." The Board finds that this purported argument does not comply with the regulations and Board Rules that require providers to *fully* develop their position in the Final Position Paper because the Provider merely lists a case name and attaches the case's reply brief without any specific analysis or discussion on how those arguments within the reply brief for that other case apply and are incorporated into the specific facts and circumstances of the instant appeal.

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

> (2) . . . . Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue.*[17]

Similarly, Board Rule 25.1.1 provides that a fully developed narrative includes applying the material facts to the controlling authorities. Therefore, the Board finds that the Provider did not comply with the regulation and Board Rules governing content requirements for Final Position Papers with respect to its purported *Advocate Christ* argument. Moreover, some of the arguments outlined in the *Advocate Christ* brief appear to be the same as those in the group case issue statement, discussed above, particularly the argument on the term "entitled," and therefore would be subsumed in that appeal.

In summary, the Board finds that Issue 1 in the instant appeal and the group issue from 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 2015), the Board dismisses this component of the DSH Payment/SSI Percentage (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.

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[16] Emphasis added.
[17] Emphasis added.

1. Second Aspect of Issue 1

The Board first notes that the Provider's Final Position Paper does not mention this sub-issue, and the MAC also did not address it in its jurisdictional challenge. Nonetheless, 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—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 appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature. Accordingly, the Board dismisses this aspect of Issue 1 as well.[18]

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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 two issues remain pending, the case 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 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:

6/1/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

[18] 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.

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Memorial Hospital (Provider Number: 39-0101)
FYE: 06/30/2015
Case Number: 19-0499

Dear Messrs. Summar and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 19-0499. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 19-0499

On May 29, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015.

On November 20, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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

[1] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] This issue was withdrawn on May 18, 2023.
[3] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

Systems. Accordingly, on June 17, 2019, the Provider transferred Issue #2 to Case No. 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

In PRRB Case No. 18-0552GC, the Provider described its DSH/SSI Percentage (Systemic Errors) issue, which is being appealed from the same NPR as the instant appeal for the same fiscal year end, 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.[6]

On May 18, 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

[5] Issue Statement at 1 (Nov. 20, 2018).
[6] Group Issue Statement in PRRB Case No. 18-0552GC (Jan. 18, 2018).

> some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare Fraction. The [provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[7]

MAC's Contentions

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a Provider election. It is not a final MAC determination. A Provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[8]

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.[9]

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[7] Emphasis added.
[8] Jurisdictional Challenge at 7 (Feb. 21, 2019).
[9] *Id*. at 5-6.

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."[10] 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."[11]

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 2015, resulting from its understated SSI percentage due to errors of omission and commission."[12]

Board Analysis and Decision:

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

A. 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*[13] 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."[14] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare

[10] Jurisdictional Response at 1 (Mar. 21, 2019).
[11] *Id*. at 2.
[12] *Id*.
[13] 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).
[14] Issue Statement at 1.

Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC similarly alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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.[18] Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

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 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 of its issue

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[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 2.0 (Aug. 2018).
[18] 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).

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[19]

[19] Last accessed February 24, 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."[20]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH – SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.[21]

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

[20] Emphasis added.
[21] (Emphasis added).

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

****

In summary, the Board hereby dismisses the 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. 19-0499 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:

6/5/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Quality Reimbursement Services, Inc.
James Ravindran
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Arcadia, CA 91006

RE: ***Duplication of Issues & Related Transfers to CIRP Group***
Case No. 22-1400 – Windham Comm. Mem'l Hosp. & Hatch Hosp. (07-0021, FYE 9/30/2019)
Case No. 22-1329GC – Hartford Health CY 2019 DSH SSI Percent. (Systemic Errors) CIRP Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject appeals in response to two transfer requests submitted on March 17, 2023 by Quality Reimbursement Services, Inc. ("QRS"/ "Representative") in the Provider's individual appeal. The background and pertinent facts with regard to these cases and the Board's Determination are set forth below.

Background & Pertinent Facts:

On **September 2, 2022**, QRS filed the individual appeal on behalf of Windham Community Memorial Hospital & Hatch Hospital ("Windham/Hatch") for FYE 9/30/2019. The individual appeal, which was subsequently closed on April 5, 2023 by transfer of the last issue, included the following 8 issues:

1 DSH Medicaid Eligible Days[1]
2 DSH SSI Percentage (Systemic Errors)
3 DSH SSI Fraction Medicare Managed Care Part C Days[2]
4 DSH Medicaid Fraction Managed Care Part C Days[3]
5 DSH SSI Unduly Narrow Definition of SSI Entitlement
6 DSH SSI & MCD Fractions -Medicare Managed Care Part C Days
7 DSH SSI Fraction Dual Eligible Days[4]
8 DSH Medicaid Fraction Dual Eligible Days

On **March 17, 2023**, QRS filed the various transfer requests, including the transfer of the DSH SSI Percentage (Systemic Errors) (#2) and the DSH SSI Unduly Narrow Definition of SSI Entitlement (#5) to the ***same*** CIRP group under Case No. 22-1329GC entitled "Hartford Health CY 2019 **DSH SSI Percentage (Systemic Errors)** CIRP Group."

[1] Issue withdrawn on April 5, 2023.
[2] Issue withdrawn on October 26, 2022.
[3] Id.
[4] QRS requested bifurcation of the Dual Eligible Days issue into separate issues for ea. fraction. On March 29, 2023, the Board bifurcated the Dual Eligible Days issue and modified Issue #7 to be for the SSI Fraction and created a new issue (#8) for the Medicaid Fraction Dual Eligible Days issue. On March 30, 2023, both issues were subsequently transferred to group appeals.

After further review of the issue statement uploaded for the SSI Percentage (Systemic Errors) and the DSH SSI Unduly Narrow Definition of SSI Entitlement issues, the Board notes that the Provider issue statements are identical for both issues. According to the issue statement, the Provider is protesting CMS's "arbitrary" policy of excluding unpaid SSI days from the numerator of the Medicare fraction:

> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr*., 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect eligibility for SSI benefits.

The issue statement in the CIRP group (*i.e.*, Case No. 22-1329GC) to which QRS is requesting the two issues be transferred includes similar language related to the Supreme Court's *Empire* decision (regarding entitlement to paid and unpaid Part A days),[5] and also relates to SSI Systemic errors and problems that exist in the data match process and a discussion of the SSI codes.

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 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.

With regard to group appeals, the regulation at 42 C.F.R. § 405.1837(a) states:

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—
>
> (1) The provider satisfies individually the requirements for a Board hearing under §405.1835(a) or §405.1835(c), except for the $10,000 amount in controversy requirement in §405.1835(a)(2) or §405.1835(c)(3).

[5] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022).

> (2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
>
> (3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.

The Board is bound by the statutes and regulations, including those governing CIRPs, specifically, 42 C.F.R. § 405.1837(b)(1)(i) which requires that commonly owned or controlled providers file single groups for the same issue occurring in the same year. Board Rule 12.2 also references the fact that, "[t]he matter at issue in the group appeal must involve a *single* question of fact or *interpretation* of law, regulation, or CMS Rulings that is common to each provider in the group."[6]

Accordingly, for purposes of the Hartford HealthCare organization and its appeal of the CY 2019 SSI Percentage (Systemic Errors) issue in Case No. 22-1329GC –there may be only one group and that group must include only a single disputed issue. With regard to the SSI Percentage (Systemic Errors) and the DSH SSI Unduly Narrow Definition of SSI Entitlement issues in Case No. 22-1400, the Board finds that Windham/Hatch appealed duplicate issues. This is evidenced by the fact that the uploaded issue statements for both Issues #2 and #5 are identical. In addition, the fact that the Provider requested the transfer of both issues to the ***same*** CIRP group further confirms that the issues are, actually, duplicative, which is in conflict with ***Board Rule 4.6****, which specifically prohibits "Duplicate Filings."*

Therefore, the Board hereby reinstates Case No. 22-1400 in order to dismiss the Unduly Narrow Definition of SSI Entitlement issue (Issue #5) from Case No. 22-1400 as a prohibited duplicative of the DSH SSI Percentage (Systemic Errors) Issue (Issue #2). Relatedly, the Board hereby denies the Provider's request to transfer the DSH SSI Unduly Narrow Definition of SSI Entitlement issue (Issue #5) from Case No. 22-1400 to Case No. 22-1329GC.[7] Upon dismissal of the issue, no issues remain, and the case is closed.

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

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

FOR THE BOARD:

6/6/2023

X Clayton J. Nix

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

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

[6] Board Rules v 3.1 issued Nov. 1, 2021.
[7] Participant #4 (Windham/Hatch) which is based on the DSH SSI Unduly Narrow Definition of SSI Entitlement issue is dismissed from Case No. 22-1329GC.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Moberly Regional Medical Center (Provider Number: 26-0074)
FYE: 10/31/2015
Case Number: 19-0512

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0512. The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 19-0512*

On May 30, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end October 31, 2015.

On November 20, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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. Accordingly, on June 17, 2019, the Provider transferred various issues to CIRP Groups, including Issue #2 to Case No. 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group.

[1] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] This issue was withdrawn on March 2, 2023.
[3] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On June 17, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

The last issue remaining in the appeal is the DSH Payment/SSI Percentage (Provider Specific) issue.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

In PRRB Case No. 18-0552GC, the Provider described its DSH/SSI Percentage (Systemic Errors) issue, which is being appealed from the same NPR as the instant appeal for the same fiscal year end, 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.[6]

On July 16, 2019, the Provider submitted its preliminary position paper to the MAC. 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 (October 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

[5] Issue Statement at 1 (Nov. 20, 2018).
[6] Group Issue Statement in PRRB Case No. 18-0552GC (Jan. 18, 2018).

> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

MAC'S Contentions:

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies for this issue. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[8]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[9]

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[7] Provider's Preliminary Position Paper at 8-9 (Jul. 16, 2019).
[8] Jurisdictional Challenge at 6 (Feb. 8, 2019).
[9] *Id*. at 5.

Provider's 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."[10] 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."[11]

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 2015, resulting from its understated SSI percentage due to errors of omission and commission."[12]

Board Analysis and Decision:

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

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1 in the present appeal —the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH 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)."[14] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was

[10] Jurisdictional Response at 1 (Mar. 11, 2019).
[11] *Id*. at 2.
[12] *Id*.
[13] Issue Statement at 1.
[14] *Id.*

incorrectly computed . . . .” and it “. . . disagrees with the [Medicare Contractor]’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”[15]

The Provider’s DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS’ regulation interpretation for the SSI percentage is clearly not “specific” to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 18-0552GC. 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.[17] Provider’s reliance upon referring to Issue 1 as “Provider Specific” and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged “provider specific” errors can be distinguished from the alleged “systemic” issue rather than being subsumed into the “systemic” issue appealed in Case No. 18-0552GC.

To this end, the Board also reviewed the Provider’s Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider’s Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers “to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties’ positions.” Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged “errors” in its Preliminary Position Paper and include *all* exhibits.

---

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

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[18]

[18] Last accessed February 24, 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."[19]

In summary, the Board finds that the first aspect of issue #1 in the instant appeal and the group issue from Group Case 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is, also, 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 and this aspect of Issue 1 is dismissed.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal, in its entirety, 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. 19-0512 and removes it from the Board's docket.

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

[19] Emphasis added.

Board Members Participating:

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

For the Board:

6/7/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case Nos. 21-0008GC, *et. al* (*see* attached listing marked as Appendix A)
Case Nos. 13-2324GC, *et. al* (*see* attached listing marked as Appendix B)
Case Nos. 14-0629GC, *et. al* (*see* attached listing marked as Appendix C)

Dear Messrs. Ravindran and Berends:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS"), the Providers' designated representative, filed the following 3 separate *consolidated* requests for expedited judicial review ("EJR") identified as "Groupings" A, B, and C and involving, in the aggregate, 36 group cases and 643 participants:

Date of EJR Request	Lead Case	Groups	Participants in Aggregate	*Hereinafter Referred To As*
Feb. 11, 2022	Case No. 21-0008GC	10 (*see* Appendix A)	46	"Grouping A"
Feb. 17, 2022	Case No. 13-2324GC	12 (*see* Appendix B)	521	"Grouping B"
Mar. 9, 2022	Case No. 14-0629GC	14 (*see* Appendix C)	76	"Grouping C"

Due to each grouping's sheer size (and age of the Groupings B and C cases), the recent closure of group cases in each grouping, the number of Medicare contractors involved with each grouping, and anticipated or planned jurisdictional and substantive claim challenges,[1,2] Federal Specialized Services ("FSS"), the Medicare Contractors' representative, requested an extension of time to review the cases covered by Grouping A on February 17, 2022, Grouping B on February 24, 2022, and Grouping C on March 14, 2022. QRS did not oppose FSS' extension requests in any of the groupings.

[1] For Grouping A, FSS' response to the consolidated request confirmed that it was reviewing whether to file jurisdictional or substantive claim challenges and represented that Substantive Claim Challenges were being filed in connection with Provider No. 45-0686 (FY 2016) in Case Nos. 21-0237G and 21-0239G.
Similarly, for Grouping B, FSS' response to the consolidated request asserted that jurisdictional impediments had already been noted in Case No. 17-0575GC with respect to Provider No. 26-0015 for failure to file a timely appeal and that "the various providers have effectively abandoned their appeals through their failure to develop or present any information in support of their claims for additional days."

[2] As explained in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items." *See* 42 C.F.R. §§ 405.1873(a), 413.24(j).

The Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") on February 25, 2022 for Groupings A and B and on March 22, 2022 for Grouping C. The Scheduling Order took the following actions for each group:

1. Granted FSS' extension request in light of the number of cases involved in the EJR request, the number of participants and MACs involved in those cases, and the fact that the final SOP for the majority (if not virtually all) of these cases was filed *within 60 days* of QRS' EJR request and that, in the past two months, QRS and another representative have *each* filed EJR requests in over 100 groups (CIRP and optional groups) for the same issue;

2. Issued a Scheduling Order to manage the jurisdictional review process for the cases within the relevant grouping and assigning ongoing tasks to *both* parties; and

3. Issued notice to the parties of the Board's position that the 30-day period for responding to an EJR request does not begin until the Board finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2).

Following the Board's Scheduling Order, the Providers were ***silent*** *and* filed ***no objections*** *or requests for clarification with regard to the Scheduling Order itself*. As a result, the Board and the Medicare Contractors continued to take actions consistent with that Scheduling Order.

On May 6, 2022, the Board received a request from OAA that asked for a copy of the administrative record and indicated that QRS had filed suit in federal district court for some of these 36 group cases.[3] Shortly thereafter on May 19, 2022, QRS timely filed its response in Groupings A, B, and C to the Medicare Contractor's filing under the Scheduling Order. Within its response, QRS: (1) obliquely notified the Board that "they have commenced an action in federal court"; and (2) indicated that their litigation was initiated because 42 U.S.C. § 1395oo(f)(1) requires that the Board issue a determination on an EJR request within 30 days and that "the Board . . . failed to render its decision within such thirty-day period."[4] However, QRS' filing failed to include any information about that litigation impacting Groupings A, B, and C (*e.g.*, QRS did not specify when and where the litigation was filed/initiated, list exactly what cases the litigation encompassed, or include a copy of the relevant complaint(s)).

[3] The March 30, 2022 Amended Complaint in the California Central District Court for Case No. 22-cv-02648 makes clear at ¶¶ 3, 34 with references to Exhibit I (a copy of the Board's February 25, 2022 Scheduling Order for Grouping A) that litigation applies both to 14 group cases included in the consolidated EJR requests for Grouping A and to the directive in 42 C.F.R. § 405.1842(h)(3)(iii), as discussed *infra*. On March 31, 2022, QRS filed a Notice of Errata to make certain corrections to the March 30, 2022 Amended Complaint, including specifying that Paragraphs 2 [assuming it is *sic* 3], 5, 32, and 34 of the Amended Complaint also refer to Exhibits I and L which relate to Groups B and C (specifically copies of the Board's Scheduling Order for Groupings B and C issued on February 25, 2022 and March 22, 2022 respectively). For example, ¶ 34 of the Complaint states "[t]he Hospitals now file this civil action within 60 days of their receipt of the PRRB's letters attached as Exhibits A-I and L which either order EJR (Exhibits E and F) or evidence conclusively that the PRRB had no intention of deciding, and in fact will not decide, the Plaintiffs' EJR requests within the thirty days as prescribed by statute." The Board is reviewing and reconciling OAA's request for records with the Complaint.

[4] Response to FSS' Scheduling Order Submission for Group A at 1; Response to FSS' Scheduling Order Submission for Group B at 1; Response to FSS' Scheduling Order Submission for Group C at 1.

A review of public records confirmed that QRS had filed litigation 44 days prior to its May 13, 2022 notice to the Board. Specifically, on March 30, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by joining an already-pending lawsuit in the U.S. District Court for the Central District of California ("California Central District Court") under Case No. 22-cv-00989 seeking judicial review on the merits of its consolidated EJR request in these 36 group cases encompassed by Groupings A, B, and C. Significantly, this litigation was filed just ***21 days after QRS*** *had filed its consolidated EJR request for Grouping C* ***and only 7 days after*** *it had filed its consolidated EJR request for Grouping A*. This less-than-30-days timing demonstrates that QRS had no intention of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented that statutory provision. QRS' failure to immediately notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

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

Procedural Background:

The Scheduling Orders issued in Groupings A, B, and C explained that, on March 26, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[5] The Scheduling Orders further explained that, as a result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis had resumed telework status. While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decision. Accordingly, the Scheduling Orders for Groupings A and B notified the parties in these cases that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals. The notice for Grouping A and B[6] was as follows:

> As you are aware, Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish

[5] Effective May 11, 2023, the Secretary ended the order finding that public health emergency exists as a result of COVID 19. *See* https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html#:~:text=That%20means%20with%20the%20COVID,the%20expiration%20of%20the%20PHE.

[6] The Scheduling Orders for Groupings A, B, and C were largely the same with only minor differences.

> jurisdiction, *i.e.*, **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**.[7]

In addition, the Scheduling Orders set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that:

> A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request '[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]' [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request).[8]

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

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

Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.[9]

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[7] (Emphasis added and footnotes omitted.)
[8] (Emphasis in original.)
[9] (Footnote omitted and bold and underline emphasis added.)

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' extension requests in Groupings A, B, and C. Nor did QRS file any objection to the Scheduling Orders issued for Groupings A, B, and C, much less notify the Board (or the opposing parties) that it had filed litigation in federal district court *until well after the Scheduling Orders had been in effect*. Rather, QRS chose to remain silent.[10]

With filings made in late February, April, and early May, FSS complied with the Board's Scheduling Orders and filed jurisdictional and substantive claim challenges in distinct group cases and raised concerns regarding the sufficiency of the EJR request itself.[11] These challenges were different from, and in addition to, any pending, unresolved, jurisdictional challenges.

Notwithstanding the numerous jurisdictional and substantive claim issues and other concerns identified by the Medicare Contractors and the Board,[12] QRS made clear by filing the Complaint in federal district court on March 30, 2022, that it was bypassing and abandoning the Board's prerequisite jurisdictional review process. In particular, even though QRS initiated the litigation only 21 days after filing the consolidated EJR request for Grouping C and only 8 days after the Board issued its Scheduling Order for Grouping C, QRS failed to promptly notify the Board of this litigation and its immediate impact on the Board proceedings. It was only through an OAA request for records on May 6, 2022 that the Board learned of QRS' litigation.

The avoidable delay in learning of QRS' bypassing and abandoning the Board's jurisdictional and EJR review process caused a significant waste of the Board's limited resources, as well as those of FSS and the Medicare Contractors servicing the 643 participants in the 36 group cases.[13] More concerning is QRS' near-concurrent filing of litigation for Grouping C, without notice to the Board, because it demonstrates QRS' bad faith and lack of intention to comply with the Board's Scheduling Orders and the administrative review process for EJR requests as mandated by 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842. Through its actions, QRS essentially self-declared that the participants in Grouping C have an immediate right to pursue relief in federal district court

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[10] This silence extended to other similar Scheduling Orders that the Board issued with respect to EJR requests filed by QRS in other cases. *See* **Appendix E**.

[11] The Medicare Contractor raised a number of concerns regarding the sufficiency of the EJR request and whether the Providers had effectively abandoned these cases by failing to properly develop the factual record and to fully set forth the merits of its legal position. In particular, the Medicare Contractor notes that no participant in the identified groups have identified a single day at issue (whether removal from the SSI fraction or addition to the Medicaid fraction). *See, e.g.*, Medicare Contractor Rule 22 letters filed in Case Nos. 13-2324GC (Feb. 18, 2022), 13-2328GC (Apr. 14, 2022), 15-0580GC (Feb. 22, 2022), 15-0586GC (Feb. 22, 2022), 15-1622GC (Feb. 22, 2022), 15-1624GC (Feb. 22, 2022), 16-0678GC (Feb. 22, 2022), 16-0679GC (Feb. 22, 2022), 17-0575GC (Feb. 22, 2022), 17-0577GC (Feb. 22, 2022). QRS' May 19, 2022 filing responds to the concerns raised by the Medicare Contractor but the response is pithy and brief.

[12] *See* **Appendix D** for a preliminary overview of the jurisdictional, claims filing, substantive claim issue and other concerns raised in these appeals.

[13] The Board takes administrative notice that it has a very large docket of pending cases (9142 as of May 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. The Board further notes that it experienced record concentrations of EJR requests being filed in the 6-month period from December 20, 2021 through June 30, 2022. Indeed, in this period, EJR requests covering 642 cases were filed, of which close to 80 percent were filed either by QRS or HRS (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases).

(regardless of whether the Board has 30 days to review the EJR request, much less has jurisdiction over such providers). Indeed, if the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. To illustrate this very point, the Board has included as **Appendix C**, a non-exhaustive listing of open jurisdictional challenges and substantive claim challenges and some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional material jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a lawsuit in connection with the above-referenced 36 group cases.

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[14]

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

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek**

[14] (Emphasis added.)

EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).

(2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).

****

(4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—

(i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or

(ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.

(b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.

(2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[15]

[15] (Emphasis added).

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[16] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[17]

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

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[18] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[19] The Court in *Alexandria* continued, stating:

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[16] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).

[17] (Emphasis added.)

[18] 42 U.S.C. § 1395oo(f)(1) (emphasis added).

[19] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[20]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[21] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 36 group cases, with 643 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes

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WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

[20] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

[21] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on March 30, 2022***, QRS continued to take actions in the Board proceedings in these group cases (*e.g.*, withdraw participants or cases, file updated SoPs, file position papers, file jurisdictional documents or briefs, file responses to jurisdictional challenges, file responses to jurisdictional substantive claim challenges) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[22] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these 36 group cases as highlighted in **Appendix D**.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process *and* finds jurisdiction. QRS' filing of the Amended Complaint in federal district court, without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request (even under the interpretation of 42 U.S.C. § 1395oo(f)(1) that it is advocating with respect to Grouping C).

B. Effect of QRS' Concurrent Filing of the Amended Complaint on the 36 Group Cases

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

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[23]

This regulation ***bars any further Board proceedings*** in these 36 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal

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

and, as explained below, is deferring further action in these 36 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[24] and the May 23, 2008 final rule[25] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[26]

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

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

[24] 69 Fed. Reg. 35716 (June 25, 2004).
[25] 73 Fed. Reg. 30190 (May 23, 2008).
[26] 69 Fed. Reg. at 35732.

> decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[27]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' concurrent filing of the Amended Complaint in the California Central District Court on March 30, 2022 prohibits the Board from conducting any further proceedings on the consolidated EJR requests for Groupings A, B, and C as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation is tantamount to bad faith and actively created the confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[28] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to

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[27] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

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

> dealings with the opposing party, the Board, and/or any relevant nonparty.

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[29]

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

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file jurisdictional challenges in Groupings A, B, and C.

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

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Orders for Groupings A, B, and C. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders violates QRS' obligations under Board Rules 1.3, 5.2, and 44. These QRS failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[30]

3. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[31] and Board Alert 19. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. The Board was not able to operate normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Orders for Groupings A, B, and C to memorialize, and effectuate, the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[32] or take other actions, ***prior to*** QRS filing its March 30, 2022 Amended Complaint. Indeed, in connection with Grouping C, QRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[33]

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

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

[32] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 16-20, and accompanying text.

[33] *See supra* note 30 (discussing how the FRCP supports the Board's position).

4. QRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

   a. The Board, in its Scheduling Orders issued for these cases (as well as for other cases prior to March 30, 2022 as set forth in **Appendix D**), made clear the Board's position that the 30-day period for responding to the EJR request would not commence until the Board had completed its jurisdictional review and issued its jurisdictional findings.

   b. The Board and the Medicare Contractors were all acting in reliance on the authority of those Scheduling Orders.

   c. Notwithstanding its March 30, 2022 filing of the litigation in the California Central District Court, QRS subsequently filed preliminary or final position papers in certain cases and included *disingenuous* "Good Faith" statements that "[w]e also herewith notify the Board that a good faith effort was made to confer with the MAC in accordance with 42 C.F.R. § 405.1853 and Rule 25."[34] The following are examples of cases in which position papers were filed *subsequent to* the Federal Complaint being filed but prior to QRS' May 19, 2022 filing wherein it obliquely notified the Board of litigation it had filed:

      - On April 7, 2022 for Case Nos. 21-0181GC, 21-0183GC.[35]
      - On May 10, 2022 for Case Nos. 13-2324GC, 13-2328GC, 14-1072GC.[36]
      - On May 11, 2022 for Case Nos. 14-1073GC, 15-0580GC, 15-1622GC, 15-1624GC, 16-0678GC, 17-0575GC.[37]
      - On May 14, 2022 for Case Nos. 15-0586GC, 16-0679GC, 17-0577GC.[38]

      In this regard, Board Rule 25.3 specifies "[t]he Board requires the parties file a complete preliminary position paper that includes . . . a statement indicating ***how a good faith effort to confer was made*** in accordance with 42 C.F.R. § 405.1853." Notwithstanding, QRS failed to disclose that, on March 30, 2022, it had initiated litigation in the California Central District Court and how that action related to its "good faith effort to confer" with the opposing party.

5. QRS made the following disingenuous statement in ¶ 34 of the Amended Complaint (as corrected by the March 31, 2022 Notice of Errata):

   > The Hospitals now file this civil action within 60 days of their receipt of the PRRB's letters attached as Exhibits A-I and M which

[34] (Emphasis added.)
[35] For each position paper, QRS made its "Good Faith Statement" in the cover letter for the position paper filing.
[36] For each position paper, QRS made its "Good Faith Statement" in the cover letter for the position paper filing.
[37] For each position paper, QRS made its "Good Faith Statement" in the cover letter for the position paper filing.
[38] For each position paper, QRS made its "Good Faith Statement" in the cover letter for the position paper filing.

> either order EJR (Exhibits E and F) or evidence conclusively that the PRRB had no intention of deciding, and in fact will not decide, the Plaintiffs' EJR requests within thirty days as prescribed by statute.

It is disingenuous because QRS failed to notify the Board of its objection to the Board's faithful application of 42 C.F.R. § 405.1842(b)(2) (which implemented the EJR provisions in 42 U.S.C. § 1395oo(f)(1)), and did not permit the Board (or the opposing party) to potentially alter its planned course of action. It highlights the procedural quagmire that QRS created of the ongoing Board's proceedings when it pursued litigation in federal court without promptly notifying the Board.

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, March 30, 2022, prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these 36 group cases and the underlying 643 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the California Central District Court, as well as the initial litigation filed on February 14, 2022 (as discussed in great detail in **Appendix E**) raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue that were joined in its litigation in the California Central District Court.[39] More specifically, it is the Board's understanding that QRS had, on February 14, 2022, established the ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, Healthcare Reimbursement Services ("HRS") *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party): (a) QRS incorporated the above captioned 36 cases with 643 participants; and (b) HRS incorporated 120 cases involving 550+ participants. The prejudicial sandbagging is highlighted by the facts that:

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

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

2. 80 percent of these requests were filed by either QRS or HRS (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).

As a point of reference and context for these serious violations by QRS, the Board has included as **Appendix E** a copy of the closure letter it issued in those 80 QRS cases that were included in the initial February 14, 2022 Federal Complaint. Finally, this is not an isolated event because it is the Board's understanding that: (1) QRS and HRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering 178 cases with 969 participants and did so without completing the jurisdictional review process and without notice to the Board;[40] and (2) QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509.[41]

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

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded to it for further proceedings*, the Board will complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[43] Examples of available remedial actions that the Board may consider to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the 36 group cases and all underlying participants.

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

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

[41] The Board is addressing the cases impacted by this litigation under separate cover.

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

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

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

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[44] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[45]

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[44] 42 C.F.R. § 405.1868 states:

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

(Emphasis added.)

[45] 73 Fed. Reg. at 30225.

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

E. Board Decision and Order

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

1. Closes these 36 group cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends:
   - The ongoing jurisdictional review process;
   - The ongoing substantive claim review process under 42 C.F.R. § 405.1873(b) which was triggered by "Substantive Claim Challenges"[46] filed in Case Nos. 21-0132G, 21-0237G, and 21-0239G regarding certain participants' compliance with the "appropriate cost report claim" requirements in § 413.24(j); and for which the Board must complete and issue findings pursuant to § 405.1873(d)(2) prior to issuing an EJR decision;[47] and
3. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to vindicate the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[48]

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

Board Members Participating:

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

For the Board:

6/8/2023

X Clayton J. Nix

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

[46] As explained in Board Rule 44.5, "the Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items" ***as required*** *by 42 C.F.R. § 413.24(j).*

[47] Per 42 C.F.R. § 405.1873(e), the Board does not issue final substantive claim findings if the Board issues a jurisdictional dismissal decision or the Board denies EJR.

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

Enclosures:

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

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

APPENDIX A

Grouping A – List of the 10 Group Cases Covered by the Consolidated Request for EJR Filed on February 11, 2022

21-0008GC	MultiCare Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
21-0010GC	MultiCare Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
21-0132G	QRS CY 2017 DSH SSI Fraction Dual Eligible Days Group
21-0134G	QRS CY 2017 DSH Medicaid Fraction Dual Eligible Days Group
21-0181GC	Asante Health System CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
21-0183GC	Asante Health System CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
21-0237G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days (2) Group
21-0239G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days (2) Group
21-0273G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (3) Group
21-0286G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (3) Group

APPENDIX B

Grouping B – List of the 12 Group Cases Covered by the Consolidated Request for EJR Filed on February 17, 2022

13-2324GC	QRS HMA 2009 DSH Dual Eligible Days CIRP Group
13-2328GC	QRS HMA 2008 DSH Dual Eligible Days CIRP Group
14-1072GC	QRS HMA 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-1073GC	QRS HMA 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0580GC	QRS HMA 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0586GC	QRS HMA 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1622GC	QRS HMA 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1624GC	QRS HMA 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
16-0678GC	QRS HMA 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0679GC	QRS HMA 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-0575GC	QRS HMA 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
17-0577GC	QRS HMA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX C

Grouping C – List of the 14 Group Cases Covered by the Consolidated Request for EJR Filed on March 9, 2022

14-0629GC	QRS Novant 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
14-0630GC	QRS Novant 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2216GC	QRS Novant 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1151GC	QRS Novant 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1580GC	QRS Novant 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-1581GC	QRS Novant 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-3027GC	QRS Novant 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-3030GC	QRS Novant 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
16-2357GC	QRS Novant 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
16-2358GC	QRS Novant 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-2275GC	QRS Novant 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-2278GC	QRS Novant 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-1521GC	QRS Novant 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-1523GC	QRS Novant 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX D

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[49]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process. This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving 36 group cases with 643 participants and when many of those cases are older cases (7+ years old).

In compliance with the Board's Scheduling Order in Groupings A, B, and C, the Medicare Contractors began submitting Jurisdictional and Substantive Claim Challenges[50] in their respective cases. These challenges, as well as separate challenges or jurisdictional issues raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenge regarding Participant #29 in Case No. 17-0575GC and 17-0577GC alleging that the participant should be dismissed because "the jurisdictional documentation shows that the Participant 29 appealed the issue well past the 185-deadline and was not timely." This participant appealed an NPR dated May 8, 2017 but did not file its appeal until Monday, November 13, 2017 (189 days later).[51]
- Concerns regarding the sufficiency of the consolidated EJR request and whether the Providers have effectively abandoned these cases by failing to properly develop the factual record and fully set forth the merits of its legal position in Case Nos. 13-2324GC, 13-2328GC, 15-0580GC, 15-0586GC, 15-1622GC, 15-1624GC, 16-0678GC, 16-0679GC, 17-0575GC, and 17-0577GC. In particular, the Medicare Contractor notes that no participant in these groups have identified a single day at issue (whether removed from the SSI fraction or added to the Medicaid fraction).
- Substantive claim challenges[52] were filed in Case Nos. 21-0132G, 21-0237G, and 21-0239G claiming that one or more of the participants failed to include an appropriate claim for the appealed item in dispute, as required under 42 C.F.R. § 413.24(j).

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

[50] *See supra* note 2 (describing "Substantive Claim Challenge"). Jurisdictional Challenges pertain to compliance with jurisdiction and other appeal/claims filing requirements. In this regard, the Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. A jurisdictional challenge (see Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements." (emphasis added.)).

[51] Based on these dates, the filing deadline was Thursday, November 9, 2017 (185 days after May 8, 2017 because, in accordance with 42 C.F.R. § 405.1835(a)(3), providers must submit their appeal to the Board no later than 180 days of the date of receipt by the provider of the final contractor determination and, per § 405.1801(a), the term "date of receipt" is defined as being presumed to be 5 days after the date of issuance). As Friday, November 10, 2017 was a federal holiday, the next business day was Monday, November 13, 2017 and, as such, would be after the filing deadline.

[52] *See supra* note 2 (discussing what the Board's use of the term "substantive claim challenge" means).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 36 group cases, has identified ***numerous, material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board's review is based on the SoPs filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[53] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

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

    a. *NPR-Based Appeals*.—For those appeals that are based on a determination such as an NPR or revised NPR, 42 C.F.R. § 405.1835(a)(3) (2013) specifies that "[u]nless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no *later than 180 days* after the date of receipt by the provider of the final contractor or Secretary determination." As the date of Provider's receipt of the determination is presumed to be 5 days after the date the final determination is issued,[54] an appeal request of a determination effectively must be filed with the Board within 185 days of the determination in order to be considered timely. The Board is reviewing whether participants failed to timely appeal and expects that it may identify situations where participants did, in fact, fail to timely appeal given the fact that, in a number of cases where certain participants appealed from the nonissuance of an NPR, the Board requested additional documentation to establish the date the Provider filed the perfected cost report at issue. In addition to the ones raised by the Medicare Contractor (*see* above), the Board has identified potential timeliness issues in the following cases:

        - Case Nos. 15-1580GC and 15-1581GC where QRS failed to include proof of delivery of the direct-add requests filed for Participant ## 2 and 5 to establish that they were timely filed per Board Rule 21.3.2;[55]
        - Case Nos. 17-0575GC and 17-0577GC where Participant #34 filed its appeal one day beyond the filing deadline.[56]

    b. *Appeals Based on Nonissuance of NPR*.—For appeals based on the nonissuance of an NPR, 42 C.F.R. § 405.1835(c)(2) specifies that: "[u]nless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for

[53] *See also* Board Rule 20.1 (Aug. 2018).
[54] 42 C.F.R. § 405.1801(a) includes the definition for "date of receipt" and paragraph (1)(iii) of that definition explains that "[t]his [5-day] presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date."
[55] Providing copies of dated forms is insufficient proof to establish when the Board received the documents for filing. The schedule of providers must include the relevant documentation to support jurisdiction of each of participating providers and documentation to establish each participant met the claims filing requirements is a requisite part. Accordingly, Board Rule 21.3.2 states: "In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue."
[56] Per the SoP, the Provider filed its appeal on Tuesday, January 30, 2017, the 186th day following the July 28, 2016 NPR.

issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) . . .)." In this instance, the appeal must be filed within 12 months of the Provider's filing of the relevant perfected cost report and, as explained at Board Rule 21.2.2, the SoP must contain the following documents to establish that the cost report was, in fact, filed and when that filing occurred:

- evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
- evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal. (*See* Board Rule 7.5.)[57]

There are a significant number of participants that appealed from the nonissuance of an NPR, and the Board has identified situations where QRS has failed to include the requisite documentation in the SOP to establish that such appeals were timely. For example, in Case No. 15-1580GC and 15-1581GC, multiple participants appealed from the nonissuance of an NPR but QRS failed to include any evidence to confirm both that the cost report was in fact filed and when that cost report was filed.[58] As a result, the Board is unable to confirm whether these appeals were timely per the filing requirements in § 405.1835(c)(2).

2. *Unauthorized Representation of Participants*.— The Board has identified situations where QRS appears to have *failed* to obtain proper ***prior*** authorization from the provider to be a participant in the relevant group.[59,60] This ***prior*** authorization is required to be placed behind Tab H for each participant, as noted by Board Rule 21.9.2, to confirm the participant gave ***prior*** authorization to join the group. The Board has initiated review of the potential dismissals due to the failure of QRS to obtain prior authorization prior to the direct addition of a provider.

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[57] Board Rule 7.5 specifies the documentation requirements for appeals based on the nonissuance of a final determination and requires such appeals to include: "evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal" and "evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal."

[58] For the following participants, QRS only included, behind Tab A, copies of emails from August 2014 to the Medicare Contractor wherein Community Health Systems "request[s] verification of the date of receipt and acceptance of . . . submitted cost reports" and opining that "the easiest way to verify these dates would be to provide print screens from the STARs system which tracks the relevant dates": Highlands Reg. Med. Ctr. (Prov. No. 10-0049, FYE 9/30/2012); Brooksville Regional Hospital (Prov. No. 10-0071, FYE 9/30/2012); Wuesthoff Memorial Hospital-Rockledge (Prov. No. 10-0092, FYE 9/30/2012); St. Cloud Reg. Med. Ctr. (Prov. No. 10-0302, FYE 12/31/2012); Chester Reg. Med. Ctr. (Prov. No. 420019, FYE 9/30/2012); Tennova Healthcare-LaFolette Med. Ctr. (Prov. No. 44-0033, FYE 9/30/2012); Tennova Healthcare-Jefferson Mem. Hosp. (Prov. No. 44-0056, FYE 9/30/20212); Tennova Healthcare (Prov. No. 44-0120, FYE 9/30/2012); Tennova Healthcare Newport Med. Ctr. (Prov. No. 44-0153, FYE 9/30/2012). However, QRS did not include any print outs from the STAR system in the SoP (or even explain why that documentation was not included).

[59] Per Board Rule 6.4 (Mar.2013, July 2015), "An authorized representative of the Provider must sign the [individual provider] appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider." The Board requires provider-executed letters of representation to be filed *with the appeal* (*i.e.*, to be obtained ***prior to*** taking actions on behalf of the provider) in order to protect providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

[60] Per Board Rule 12.4(A) (2015), "The Board will recognize a single Group Representative for all Providers in the group. The Providers filing the initial appeal must appoint the Group Representative by attaching an Authorization of Representation letter on each Provider's letterhead, signed by an owner or officer of the Provider." To this end, the Model Form E (2015) for Direct Add Appeals specifies, "[i]f you are filing as a representative, YOU **MUST** ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4." (Emphasis in original.)

For example, Grouping C pertains to only one healthcare chain, Novant Health ("Novant"). Case Nos. 15-1580GC, 15-1581GC, 15-3027GC, and 15-3030GC *only* have a global letter from Novant dated February 8, 2019 (several years after the participant's direct-add appeals were filed in most cases). Similarly, Case Nos. 16-2357GC, 16-2358GC, 17-2275GC, and 17-2278GC *only* have a global letter from Novant executed on September 2, 2020 (several years after most participants were direct-added to the appeals). The Board also has concerns about the integrity of these *post-hoc* global representation letters because the first page executed by the Novant is generic without reference to specific providers or fiscal years and the attached chart wherein that information is included is the exact same for both letters having the same formatting, the same providers and the same multi-fiscal year listings.[61]

3. *Failure to meet minimum $50,000 AiC requirement for a group appeal*. —As explained in 42 C.F.R. § 405.1839(b): "[i]n order to satisfy the amount in controversy ["AiC"] requirement . . . for a Board hearing as a group appeal, the group must *demonstrate* that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."[62] Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ." The following are examples of group cases that that Board is reviewing to determine whether the group failed to meet the minimum $50,000 AiC requirement.

   a. *Case Nos. 21-0008GC and 21-0010GC*—The SoP for each case lists an aggregate amount in controversy that is less than the minimum $50,000 threshold. However, QRS failed to recognize that its groups failed to meet this mandatory requirement for a group appeal and did not request any action on the Board to cure this fatal defect.

   b. The Board expects that it would identify additional AiC issues if it were to complete its jurisdictional review, and such issues may include: (1) failure to document in the final SoP that the group meets the minimum $50,000 threshold ***for the group issue*** as explained at 42 C.F.R. § 405.1839(b);[63] and (2) the dismissal of participants for other reasons which may cause the group to fail below the minimum $50,000 AiC threshold.[64]

      - For example, in Case Nos. 14-1072GC and 14-1073GC, the Board is reviewing whether the AiC calculations included behind Tab E are good faith AiC calculations in

[61] For example, on *both* attachments, for Forsyth Medical Center the FYEs listed are "6/30/1997, 12/31/1997 – 12/31/2018"; for Presbyterian Medical Center the FYEs listed are "9/30/1997, 12/31/1998-12/31/2002, 12/31/2004-2018"; for Thomasville Medical Center the FYEs are listed as "12/31/1999-12/31/2000, 12/31/2007-2018."
[62] Consistent with 42 C.F.R. § 405.1840(a), Board Rule 6.3 (2013) requires that "*[f]or each issue*, provide a calculation or support demonstrating the amount in controversy." (Emphasis added.)
[63] The Board is aware of situations where the AiC calculation in the SoP is ***not*** *for the group issue* or fails to be a good faith calculation. *See also* 42 C.F.R. § 405.1837(c) (specifying among other things that the content of a group appeal request must including the following: "If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.).
[64] As a significant portion of the groups are small or close to the minimum $50,000 AiC threshold, it is likely that a number of groups may fail to meet this threshold once the Board completes its jurisdictional review.

compliance with 42 C.F.R. § 405.1839(b). Case No. 14-1073GC relates to the *Medicaid fraction*; however, the AiC calculations included for that case did ***not*** change any of the listed data for *Medicaid fraction*, but rather ***increased*** the SSI fraction by 0.001 due to "SSI/Dual Days into Medicaid fraction numerator." Indeed, the Medicaid fraction section has a line entitled "Medicaid Dual Eligible Days (ex. Exhausted days)" but it is left *blank*. Further, these calculations contain no explanation. Finally, the hollow/artificial nature of the AiC calculations is punctuated by the fact that the companion SSI fraction case under Case No. 14-1072GC largely[65] includes the ***same*** 0.001 adjustment to the SSI fraction but under a different line entitled "SSI/Dual Days Out of SSI Fraction Denominator."[66]

- Some of the SSI fraction CIRP groups base the AiC calculation simply on a 0.25 percent change in the SSI fraction. However, there is no explanation given regarding the basis of that estimated amount or why that amount would apply uniformly to all participants in the CIRP group.[67] An example is Case Nos. 21-0273G.
- Some of the Medicaid fraction CIRP groups base a participant's AiC calculation on the *generic*, blanket addition of 50 days to the numerator of the Medicaid fraction without explaining that estimated amount or why that amount would apply uniformly to *all* participants in the group. For example, Case No. 17-0577GC has 52 participants; yet the AiC calculation for ***all*** 52 participants is based on generically adding 50 days to the numerator of the Medicaid fraction without explanation.[68]

4. *The Compliance of Commonly Owned/Controlled Providers with the CIRP group requirements*.—Pursuant to 42 C.F.R. § 405.1837(b)(1):

> Two or more providers *under common ownership or control* that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings *that is common to the providers*, and that arises in cost

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[65] There are some instances, such as Participant #2, where the AiC calculation for both cases clearly do ***not*** pertain to the issue appealed in the respective case. Rather, this participant's AiC calculation in Case No. 14-1073GC does ***not*** relate to *any* issue except maybe a rounding issue as the AiC simply reflects the DSH calculation from the NPR, except that raw data is not rounded up to the 4th decimal (consistent with cost reporting software calculations). Similarly, this participant's calculation in Case No. 14-1072GC relates to a Medicaid eligible days issue because it increases the Medicaid HMO days (as listed in the AiC calculation for Case No. 14-1073GC) by 16 days, while leaving the line for "Medicaid Dual Eligible Days (ex. Exhausted days)" blank.

[66] The SSI and Medicaid fractions use different factors/data in the numerator and denominator resulting in very different values. Moreover, the days that the Providers seek to add to the numerator of the Medicaid fraction (dual eligible days for which there was no payment) are only a subset of the days that the Providers seek to remove from the SSI fraction (no-pay Part A days regardless of whether they were dual eligible). Further, the removal of no-pay Part A days could impact *both* the numerator and denominator of the SSI fraction but the Providers have only focused on the Medicaid fraction. Thus, the Board questions whether QRS has included good faith AiC calculations in those instances where a participant's AiC in an SSI CIRP group matches the participant's AiC in the companion Medicaid CIRP group. *See infra* note 67.

[67] In connection with this, the Board notes that 42 C.F.R. § 405.1837(c)(2)(iii) (2013) states: "If the ***provider*** self-disallows a specific item, *a description of the nature* ***and amount*** of each self-disallowed item ***and*** *the reimbursement sought for each item*." (Emphasis added.) This provision is applicable since the regulation at issue prevented all of the providers in these groups from claiming the reimbursement that they are seeking and their appeals are based on self-disallowance (regardless of whether the as-filed cost report underlying each of their appeals included a formal protest).

[68] *See supra* note 67.

> reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must bring the appeal as a group appeal***.[69]

In these situations, the commonly owned/controlled providers must establish a common issue related party ("CIRP") group. There are 6 *optional* groups in the instant 36 cases, and the Board is reviewing compliance with the mandatory CIRP group rules because the Board has identified participants in these *optional* groups as being potentially subject to the mandatory CIRP group requirements. For example, Participant #1, MercyOne Waterloo Medical Center in Case Nos. 21-0132G and 21-0134G, is part of the MedOne Health System as evidenced by the letterhead on letter of representation included behind Tab 1H in the final SoPs filed for these cases. Similarly, Participant #9, Saint Vincent Health Center in Case Nos. 21-0132G and 21-0134G, is part of the Allegheny Health Network as evidenced by the letterhead on the letter of representation included behind Tab 9H in the final SoPs filed for these cases. Accordingly, the Board is reviewing whether these participants are properly in the *optional* group (as opposed to a CIRP group) and, if not, whether they should be dismissed.

5. *Prohibited Duplicate EJR and/or Participants that Fail to Have Both Issues Covered by the EJR Request.*— The EJR request pertains to the DSH adjustment calculation and covers two separate issues where one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation, in recognition of the fact that the Board finds that each involves a separate issue.[70] Thus, for each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that, in Grouping C, there are two years for Novant Health where QRS only included one CIRP group appeal relating to the SSI fraction. Specifically, for 2009 and 2010, in the consolidated EJR request, some providers are participants in only one of the fraction groups. Grouping C contains group

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[69] (Emphasis added.)

[70] As explained at 42 C.F.R. § 405.1837(a), providers have a right to participate in a group appeal only if "[t]he matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law*, regulations, or CMS Rulings that is common to each provider in the group." (Emphasis added.) The Board takes administrative notice that it views the challenge to the Secretary's 2004 policy to include no pay Part A days in the Medicare fraction as a separate issue from the inclusion of the subset of those days in the Medicaid fraction (*i.e.*, the SSI fraction CIRP groups involve a different interpretation of law or regulations than the Medicaid fraction CIRP groups). To that end, it has been reversing mergers of companion SSI fraction dual eligible days cases with Medicaid fraction dual eligible days cases that were made in error. In support of this position, the Board points to the Ninth Circuit's decision in *Empire* which overturned the 2004 policy change *and then simply reverted to the prior policy that resulted in no-pay Part A days being counted in neither fraction*. *See Empire Health Found. v. Azar*, 958 F.3d 873, 886 (9th Cir. 2020) ("reinstat[ing] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days", *i.e.*, reinstating the rule previously in force). Similarly, the Board points to CMS Ruling 1498-R2 confirming that no pay Part A days were not counted in either fraction prior to 2004. CMS Ruling 1498-R2 at 3 (stating "Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098)." (emphasis added)). *See also* CMS Ruling 1498-R.

appeals for Novant Health for the years 2008 through 2015. Each of the years 2008 and 2011 through 2015 consist of two separate companion CIRP groups, one relating to the SSI fraction and the other to the Medicaid fraction. However, for years 2009 and 2010, there is only one CIRP group appeal relating to the SSI fraction. Indeed, earlier on January 20, 2022, QRS filed the ***same*** EJR request in the companion 2009 and 2010 Novant Medicaid fraction CIRP groups under Case Nos. 14-2217GC and 15-1152GC respectively; however, QRS abandoned the Board's jurisdictional review process and related Scheduling Order to pursue the merits of those EJRs requests in Federal Court as documented in **Appendix E,** notwithstanding the fact that those companion cases only had the Medicaid fraction portion of the issues covered by the EJR request. As the companion cases are closed and it is apparent that Novant is already pursuing the full EJR issue for 2009 and 2011 in federal court (*see* **Appendix E**), the Board is reviewing dismissal of the 2009 and 2011 Novant SSI fraction cases in Grouping C.

6. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in these 36 groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[71] The Board expects it would identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

7. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[72] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a]

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[71] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

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

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

provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law, regulations, or CMS Rulings* that is common to each provider in the group.[73] The Board is reviewing whether the Providers' consolidated EJR requests filed for Groupings A, B and C are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[74]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[75]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[76] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[77] and, as relevant, whether it requested transfer of those additional issues to the group; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[78]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[79] A critical aspect of the

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[73] (Emphasis added.)

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

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

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

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

[78] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Cases where the Providers' preliminary position paper was filed prior to the relevant consolidated EJR request being filed include: Case Nos. 21-0237G, 21-0273G and 21-0239G where the position paper was filed in January 2022.

[79] Indeed, the Board is aware that, notwithstanding the fact that it is pursing the merits of its EJR requests in federal district court, it subsequently filed preliminary position papers in the following cases and that these position papers include not just the *Empire* issue but also another separate and distinct issue that the Board refers to in Board Rule 8 as the SSI eligible days issue embodied in PRRB Dec. No. 2017-D12:

- On April 25, 2022 for Case Nos. 19-2534GC, 19-1045GC.
- On May 12, 2022 for Case No. 19-0805GC.
- On June 6, 2022 for Case Nos. 14-2400GC, 14-3295GC, 14-3474GC and 15 2493GCGC.
- On June 13, 2022 for Case Nos. 17-1461GC and 20-1254GC.
- On June 17, 2022 for Case No. 20-1685GC.
- On July 20, 2022 for Case No. 19-1541GC.

The arguments made in these position papers supports the Board's position that the SSI eligibility issue is a separate issue from the *Empire* no pay Part A days issue because each issue involves a different *interpretation* of the relevant statutory provisions, is challenging a different regulatory provision, and seeks different relief since they each involve different types of days (one is seeking removal of no pay Part A days from all of the Medicare fraction while the other is seeking the addition of SSI eligible days to the numerator of the Medicare fraction). *See* 42 C.F.R. § 405.1837(a)(2) (stating providers have a right to participate in a group appeal only if "[t]he matter at issue in the group appeal involves

> jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the March 30, 2022 filing of the Amended Complaint in federal district court, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above).

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a single question of fact or ***interpretation*** *of law*, regulations, or CMS Rulings that is common to each provider in the group" (emphasis added)); 42 C.F.R. §§ 405.1835(b), 405.1837(c); Board Rules 7, 8, 12.2, 13, 16, 16.2.

APPENDIX E

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

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Mail Stop: B1-01-31
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Via Electronic Delivery

Scott Berends, Esq.
Federal Specialized Services
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James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[93] 42 C.F.R. § 405.1868 states:

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

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

(1) Dismiss the appeal with prejudice;

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

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

(Emphasis added.)

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

* * * * *

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

Board Members Participating:

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

For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

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

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

LIST OF 80 GROUP CASES

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nathan Summar
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Mary Black Health System Gaffney (Provider Number: 42-0043)
FYE: 12/31/2017
Case Number: 21-0323

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 21-0323. The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 21-0323*

On June 15, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017.

On December 1, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Issues)[1]
3. DSH Payment – Medicaid Eligible Days[2]

The remaining issue is the DSH Payment/SSI Percentage (Provider Specific) issue.

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

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

[1] On June 23, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on March 2, 2023.

> 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]

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

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

On July 30, 2021, the Provider submitted its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This based on certain data from the State of South Carolina and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of South Carolina 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,

[3] Issue Statement at 1 (Dec. 1, 2020).
[4] *Id*. at 2.

> 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[5]

MAC'S Contentions:

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for two reasons. The MAC contends that the Provider has abandoned the SSI realignment sub-issue because it did not brief this issue in the preliminary position paper, in violation of PRRB Rule 25.3.[6] In the alternative, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with other jurisdictional decisions.[7]

[5] Provider's Preliminary Position Paper at 8-9 (Jul. 30, 2021).
[6] Jurisdictional Challenge at 6 (Sept. 30, 2021).
[7] *Id*. at 6-7.

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.[8]

Provider's Response:

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

Board Analysis and Decision:

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

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[9] 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)."[10] 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."[11]

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

[8] *Id*. at 4-6.
[9] Issue Statement at 1.
[10] *Id.*
[11] *Id.*

DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[12], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 20-0997GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

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

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, 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.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[14]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[15]

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

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

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, also, dismissed by the Board.

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[16] For cost issues relating to the DSH payment adjustment, which has multiple components, providers are required to appeal each separate DSH component as a separate issue which is described as narrowly as possible.[17]

With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

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

Board Rule 25 addresses Preliminary Position Papers. It states, in pertinent part:

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

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

> (a) The Board has full power and authority to make rules and

[16] PRRB Rule 7.
[17] PRRB Rule 8.1.

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

The Provider in this case included the SSI Realignment sub-issue in its Individual Appeal Request, but omitted it in its Preliminary Position Paper. Therefore, the Board finds this aspect of the issue has been abandoned by the Provider and dismisses it from the appeal.

In the alternative, the Board also 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.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and the Provider abandoned the SSI realignment portion of the issue by failing to include it in its Preliminary Position Paper. As no issues remain pending, the Board hereby closes Case No. 21-0323 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
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For the Board:

6/14/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Expedited Judicial Review Determination***
23-0790GC Mount Sinai Health System CY 2018 Capital DSH CIRP Group
23-0477GC Penn State Health CY 2019 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 26, 2023 *consolidated* request for expedited judicial review ("EJR")[1] in the 2 above-referenced common issue related party ("CIRP") group appeals.[2] Set forth below is the Board's decision on the EJR request.

Issue

In these group cases, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

[1] The consolidated request for EJR also included two other cases, PRRB Case No. 23-1230GC, Main Line Health CY 2019 Capital DSH CIRP Group, and PRRB Case No. 23-1097G, Bass, Berry & Sims, PLC CY 2018 Capital DSH Group. Those two cases will be decided by the Board under separate cover.

[2] Mount Sinai Health System and Penn State Health are parent organizations with multiple hospitals and are subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case Nos. 23-0790GC and 23-0477GC for the years 2018 and 2019, respectively. As Mount Sinai Health System and Penn State Health designated the respective CIRP groups fully formed, they are prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): "When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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."

[3] Request for Expedited Judicial Review, 1 (May 26, 2023) ("Request for EJR").

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[10]

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Jan. 26, 2023) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with §§1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment, the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

The Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited May 31, 2023).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $((1 + DSHP)^{0.4176} - 1))$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

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[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] *Id.* (Emphasis added.)

> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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[24] *Id.*
[25] *Id*. at 43452-53.
[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.
>
> ****
>
> Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated

[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added).

as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.*

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

****

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent

> reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).
[29] *Id*. at 47048.

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[30]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[31] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market

[30] *Id.* at 47047 (Bold and underline emphasis added.)
[31] Pub. L. 108–173

areas for use in the wage index for operating IPPS.[32] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[33]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[34] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.

[32] 69 Fed. Reg. 48916, 49026-27 (Aug. 11, 2004).
[33] *Id.*
[34] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[35]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[36] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital

[35] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[36] (Emphasis added.)

> prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[37]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment

[37] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[38]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[39] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[40]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[41]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

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[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[39] of the Department of Health and Human Services.
[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[41] *Id.*

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[42]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[43]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).

[42] *Id.*
[43] *Id.*

> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[44]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as Added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in the ***unpublished*** opinion in *Toledo Hosp. v. Becerra* ("*Toledo*"),[45] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[46]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[47] The Court also noted how Congress enacted legislation in 1999[48] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[49] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R.

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[44] (Bold emphasis added.)
[45] No. 21-5273, 2021 WL 4502052 (D.D.C. Jan. 6, 2021).
[46] *Id.* at *8 (citations omitted).
[47] *Id.* at *2.
[48] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[49] *Toledo* at *3.

§ 412.320 for large urban hospitals (the capital DSH payment).[50] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[51]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.[52]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[53] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[54]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

    - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[55]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[56]

    - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[57]

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[50] *Id.* at *3-4.
[51] *Id.* at *4.
[52] *Id.* at *5.
[53] *Id.* at *6-8.
[54] *Id.* at *11.
[55] *Id.*
[56] *Id.*
[57] *Id.*

- "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[58]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[59] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[60]

Providers' Request for EJR

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[61]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[62]

The Providers maintain that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[63] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[64] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[65]

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[58] *Id.* at *11-12.
[59] *Id.* at *12.
[60] *Id.*
[61] Request for EJR at 7.
[62] *Id.* at 1, 7.
[63] *See id.* at 7.
[64] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[65] *Id.*

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[66]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[67] Further, the Providers contend that the Secretary has conceded the issue prospectively in his most recently proposed inpatient prospective payment rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii), as follows:

> For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, *and before October 1, 2023*, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[68]

Thus, the Providers contend, if the rule is finalized, for discharges on or after October 1, 2023, "hospitals reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining eligibility for capital DSH payments" and therefore will be eligible for capital DSH.[69] However, the Providers explain that "while the Fiscal Year 2024 [] proposed rule would revise 42 C.F.R. § 413.20(a)(1)(iii) in accordance with the *Toledo* decision for discharges on or after October 1, 2023, such changes, even if finalized, would not impact the Providers as the years at issue in this request are outside the scope of the proposed amendments."[70]

The Providers further contend that since the Board is bound by the regulation being challenged,[71] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (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.

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[66] *Id.* at 8-9.
[67] *Id.* at 9, 11-12.
[68] *Id.* at 9-10, *citing* Medicare Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Policy Changes and Fiscal Year 2024 Rates, 88 Fed. Reg. 26,658, 27,307 (May 1, 2023) (emphasis added).
[69] *Id.* at 10, *citing* 88 Fed. Reg. at 27,058.
[70] *Id.* at 11-12, *citing* 88 Fed. Reg. at 27,058-59.
[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10, 12.

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[73] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[74] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in these three cases have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise these group appeals have filed appeals involving fiscal years ending in 2018 or 2019. All of the participants have appealed from an original NPR.

Based on its review of the record, the Board finds that all of the providers in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835. The providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the appealed issue. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3) in the cases at issue.[75]

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

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

> (j) **Substantive reimbursement requirement of an appropriate cost report claim**—

[73] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[74] *Id.* at 70555.
[75] In PRRB Case No. 23-0790GC, the Medicare Contractor filed a Board Rule 22 Jurisdictional Review letter on May 31, 2023, indicating there were no jurisdictional impediments related to the providers included in the groups in those cases. Further, Federal Specialized Services, on behalf of the Medicare Contractors, filed a response to the Request for EJR, indicating that there were no jurisdictional or substantive claim impediments to Providers' Request for EJR in the two cases discussed herein.

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

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

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

> **appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.[76]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[77] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[78] On May 31, 2023, Federal Specialized Services ("FSS"), on behalf of the Medicare Contractors, filed a response to the Providers' Request for EJR and, on June 2, 2023, FSS filed a revised response. In both responses, FSS indicated that there were no substantive claim impediments with regard to the two group cases discussed herein.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[79] the Board finds there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

---

[76] (Bold emphasis added.)
[77] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[78] *See* 42 C.F.R. § 405.1873(a).
[79] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR request for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these two cases, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

6/15/2023

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Wilson Leong, FSS

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Scenic Mountain Medical Center (Prov. No. 45-0653)
FYE 12/31/2015
Case No. 19-0084

Dear Messrs. Wilson and Lamprecht,

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

Background:

A. ***Procedural History for Case No. 19-0084***

On April 12, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2015.

On October 10, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

On November 30, 2018, the Provider added the Standardized Payment Amount issue; however, the Provider subsequently withdrew this issue on May 29, 2019.

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 Quorum Health. Accordingly, on May 30, 2019, the Provider transferred Issues 2, 4, and 5 to Quorum CIRP groups. As a result

[1] On May 30, 2019, this issue was transferred to PRRB Case No. 18-1333GC.
[2] On May 30, 2019, this issue was transferred to PRRB Case No. 18-0594GC.
[3] On May 30, 2019, this issue was transferred to PRRB Case No. 18-0595GC.

of these transfers and withdrawal, *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 May 29, 2019, the Provider filed its preliminary position paper and, with respect to Issue 3, promised that "the Medicaid eligible days listing [is] being sent under separate cover." Similarly, on September 27, 2019, the MAC filed its preliminary position paper.

On February 8, 2019, the MAC filed a Jurisdictional Challenge requesting that the Board dismiss Issues 1, 4, 5, and 6, of which only Issue 1 remains pending in the appeal.

On December 30, 2022, the MAC filed its final request for the Provider to submit a listing of the specific Medicaid eligible days at issue in this appeal for Issue 3 and requested that it be submitted within 30 days (*i.e*., by January 39, 2023). In filing that request, the MAC noted that it had made multiple requests since the appeal was filed in October 2018 but has not received a response.

On February 14, 2023, the MAC filed a Motion to Dismiss Issue 3 since the Provider failed to include the listing with its May 29, 2019 preliminary position paper and further failed to respond to its December 30, 2022 request for a listing of the specific Medicaid eligible days at issue in the case.

Notably, the Provider did not file a response to ***either*** the Jurisdictional Challenge ***or*** Motion to Dismiss and, with respect to each filing, the 30-day time for doing so has elapsed. 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.[4] 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."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-1333GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider

[4] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

> also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

The Provider transferred Issue 2 – DSH SSI Percentage (Systemic Errors) – to the CIRP Group under 18-1333GC, on May 30, 2019. The group issue in Case No. 18-1333GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/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.[6]

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

> **Provider Specific**

[5] Issue Statement at 1 (Oct. 10, 2018).
[6] Group Issue Statement, Case No. 18-1333GC.

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the "estimated impact" for the issue is $9,547 based on an "estimated impact" of 0.25% increase in the SSI fraction. This is the same "estimated impact" that is listed as the amount in controversy for this Provider as a participant in Case No. 18-1333GC.

C. MAC's Jurisdictional Challenge and Motion to Dismiss

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final 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.

[7] Provider's Preliminary Position Paper at 8-9 (May 29, 2019).

> . . .
>
> 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.[8]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[9]

2. Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH Payment – Medicaid Eligible Days issue, arguing:

> a. That the Provider has failed to furnish with it preliminary position paper the listing of specific Medicaid Eligible Days in dispute or describe why such documentation/information 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. . .[10]

The MAC further noted that it emailed the Provider requesting a listing of the specific Medicaid eligible days at issue from the Provider on November 8, 2018, January 31, 2019, April 28, 2021, August 31, 2021, and October 19, 2021. Finally, the MAC filed a formal request in this case requesting that the Provider provide a listing within 30 days. In all cases, the Provider was silent. Accordingly, the MAC filed its motion to dismiss Issue 3.

---

[8] Jurisdictional Challenge at 3-4 (Feb. 8, 2019).
[9] *Id*. at 2-3.
[10] Motion to Dismiss at 6 (Feb. 14, 2023).

D. Provider's Response to the Jurisdictional Challenge and Motion to Dismiss

As discussed above, the Provider did not file a response to ***either*** this jurisdictional challenge ***or*** the Motion to Dismiss and the time for doing so has elapsed.

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 Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-1333GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH Payment/SSI Percentage (Systemic Errors) issue in group Case No. 18-1333GC 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

[11] Issue Statement at 1.
[12] *Id.*
[13] *Id.*

payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue in Case No. 18-1333GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[14] the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-1333GC (which it is required to do since it is subject to the mandatory CIRP group regulation). 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] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-1333GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-1333GC, 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,[16] 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:

---

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

[15] 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).

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[17]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[18]

Accordingly, *based on the record before it*,[19] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-1333GC are the same issue. Because the

[17] Last accessed February 24, 2023.
[18] (Emphasis added.)
[19] Again, the Provider failed to respond to the Jurisdictional Challenge and the Board must make its determination based on the record before it as explained at Board Rule 44.4.3.

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

2. Second Aspect of Issue 1

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

B. DSH – Medicaid Eligible Days

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

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[20]

[20] Individual Appeal Request, Issue 3.

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.[21]

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.

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

42 C.F.R. § 405.1853 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*

[21] Provider's Preliminary Position Paper at 8.
[22] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> *timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[23]

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

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

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

> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[26]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(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

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

> data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to establish what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25 and 42 C.F.R. § 405.1853(b)(2)-(3), the Provider has the burden to present that the relevant facts and evidence as part of its position paper filing unless it adequately explains therein why such facts and evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue with its preliminary position paper as required by the controlling regulations and Board Rules. The Provider promised that it was being sent under separate cover but never made the filing. Nor has the Provider provided any explanation as to why the information and documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. The MAC has documented numerous requests and the Provider's silence demonstrates its abandonment of this issue. Indeed, without any specific days being identified in the position paper filing, the Board must assume that there are no actual days at issue and that the amount in dispute is $0 for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[28]

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[27] (Emphasis added).

[28] The Board takes administrative notice that it has issued similar dismissals of Medicaid eligible days issues due to Quorum's failure to file Medicaid eligible days listings with its preliminary position paper and that these dismissals were made in response to filing made by the MAC requesting that the Board dismiss the issue due to those failures. *See, e.g.*, Case No. 17-2247 (Board dismissal dated Aug. 26, 2022 in response to MAC Motion to Dismiss dated June 16, 2022); Case No. 19-2771 (Board dismissal dated May 1, 2023 in response to MAC Motion to Dismiss dated Feb. 28, 2023); Case No. 16-1828 (Board dismissal dated May 22, 2023 in response to MAC Jurisdictional Challenge dated March 2, 2023).

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-1333GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue and has abandoned the issue. As no issues remain pending, the Board hereby closes Case No. 19-0084 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:

6/16/2023

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Merit Health Central (Prov. No. 25-0072)
FYE 09/30/2017
Case No. 21-0433

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 21-0433***

On July 10, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On December 22, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained seven (7) issues:

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

As the Provider is commonly owned/controlled by the health care chain, Community Health Services ("CHS"), the Provider is subject to the mandatory common issue related party ("CIRP")

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

group regulation at 42 C.F.R. § 405.1837(b)(1). Accordingly, on March 30, 2021, the Provider transferred Issues 2, 3, 4, 6, and 7 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 4 (the DSH – Medicaid Eligible Days issue).

On September 1, 2021, the Provider filed is preliminary position paper.

On November 10, 2021, the Medicare filed a Jurisdictional Challenge requesting that the Board dismiss Issue 1 as a prohibited duplicate of Issue 2 which had been transferred to a CIRP group. The Provider failed to respond to the Jurisdictional Challenge within the 30-day period allowed under Board Rule 44.4.3 which 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.

On December 8, 2021, the Medicare Contractor filed its preliminary position paper.

On November 14, 2022, the MAC filed a Jurisdictional Challenge requesting that the Board dismiss Issue 5. 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 and restated its request that the Board dismiss Issue 5. The Provider did not respond to the MAC's Reply.

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

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

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

[6] Issue Statement at 1 (Dec. 22, 2020).

As the Provider is commonly owned by Community Health Systems ("CHS"), the Provider transferred its Issue 2 – DSH SSI Percentage – to the common issue related party ("CIRP") group under Case No. 20-1332GC on March 30, 2021. The group issue in Case No. 20-1332GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/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.[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $29,000.

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

> **Provider Specific**

[7] Group Issue Statement, Case No. 20-1332GC.

> 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 Mississippi and the Provider does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Mississippi and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its record 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.

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $29,479. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-1332GC.

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

In its November 10, 2021 Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.

> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[8]

Further, the MAC contends Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[9]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[10]

Issue 5 – DSH – Medicaid Eligible Days

In its November 14, 2022 Jurisdictional Challenge, the MAC argued that the Provider abandoned Issue 5, the DSH – Medicaid Eligible Days issue, because it has not submitted a list of the Medicaid eligible days at issue in this case and has not fully addressed the issue in its September 1, 2021 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: September 20, 2021 (right after the Provider filed its September 1, 2021 preliminary position paper) and September 8, 2022. However, the Provider never responded to those requests. 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

[8] Jurisdictional Challenge #1 at 6-7 (Nov. 10, 2021).
[9] *Id*. at 6.
[10] *Id*. at 4-6.

> 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.[11]

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

2. <u>Provider's Jurisdictional Response</u>

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Provider did ***not*** file a response to the November 10, 2021 jurisdictional challenge regarding Issue 1 and the 30-day time frame to respond under Board Rule 44.4.3 has lapsed.

Issue 5 – DSH – Medicaid Eligible Days

On December 14, 2022, the Provider timely responded to the Medicare Contractor's November 14, 2022 Jurisdictional Challenge regarding Issue 5. The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[12] The Provider goes on to argue:

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> 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.[13]

[11] Jurisdictional Challenge at 4, 6 (Nov. 14, 2022) (footnotes omitted).
[12] Jurisdictional Response at 1 (Dec. 14, 2022).
[13] *Id*. at 2.

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."[14] 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.

1. 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 5:

- "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."[15]

- "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.

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[14] *Id*.
[15] (Emphasis in original.)

Board Analysis and Decision:

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

A. DSH SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-1332GC.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal basis for its DSH – SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[17] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[18]

The Provider's DSH – SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH – SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH – SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

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

PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH – SSI Percentage (Provider Specific) issue.

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

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

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

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

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

> 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.[21]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[22]

Accordingly, *based on the record before it*,[23] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-1332GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH – SSI 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.

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[21] Last accessed February 24, 2023.
[22] Emphasis added.
[23] Again, the Provider failed to respond to the first jurisdictional challenge pertaining to Issue 1 and its response to the second jurisdictional challenge relating to Issue 5 did not include any response to that first jurisdictional challenge. Accordingly, consistent with Board Rule 44.4.3, the Board must on the first jurisdictional challenged based on the record before it.

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 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.[24]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[25] The Provider later argued that there are practical impediments in that providers are impacted by the State eligibility matching being currently unavailable due to a change in the State's matching vendor changes.[26]

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[24] Individual Appeal Request, Issue 5.
[25] Provider's Preliminary Position Paper at 8 (Sept. 1, 2021).
[26] Jurisdictional Response at 1.

Board Rule 7.3.1.2 (Nov. 2021) states:

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

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

Notably, the Provider's preliminary position paper promised that it would be sending the 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"[27] 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 then promises that it would be finally, *at this late date*, filing in this case a redacted Medicaid Eligible days listing; however, the Provider never did so. Accordingly, it is clear that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[28]

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

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

---

[27] (Emphasis added.)

[28] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019, *available at*: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2019-through-11-30-2019.pdf), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[29]

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

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

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

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

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

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

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

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

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

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

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

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

Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[33] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. *Based on the record before it*, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor did the Provider provided in its position paper filing any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2.[34] 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

[33] (Emphasis added).
[34] Moreover, as discussed *supra*, the Provider's belated explanation provided in its December 14, 2022 response (1¼ years after the September 1, 2021 preliminary position paper filing) was wholly inadequate and still did not contain the promised Medicaid eligible days listing at this late date.

matching being unavailable at this time *due to a change in the State's matching vendor changes*"[35] 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 a year earlier when it filed its preliminary position paper on September 1, 2021 when it suggested a listing was imminent by promising 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 issue closed more than 5 years ago.[36] Similarly, the Provider's reference to the COVID-19 pandemic has no relevance because it pertained to filing deadlines (and not the content of those filings). Here, the Provider *voluntarily* complied with the deadline and, in fact, filed its preliminary position paper on September 1, 2021 ***without any reference to Alert 19 or the pandemic***.[37] To the extent COVID-19 affected the content of that filing, then it had an obligation to explain that pursuant to Board Rule 25.2.2. Further, the Provider has failed to explain, *at this late date*, how its *generic* reference to the COVID-19 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

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[35] (Emphasis added.)

[36] 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. Indeed, the fact that an alleged listing was available as of December 14, 2022 only highlights how extremely vague and inadequate the December 14, 2022 response is because the response represented on one hand that "at this time" an impediment existed but then on the other hand represents that a redacted listing was in fact available for filing on December 14, 2022. Again, the Provider's response is extremely vague and wholly inadequate.

[37] The Board takes administrative notice that the position paper filing in this case is virtually identical to that filed in other CHS cases with the same remaining two issues. Example cases are listed in *infra* note 39 and the Board similarly dismissed them.

Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do. The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative[38] as well as cases involving CHS providers.[39] 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 DSH – SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the 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. 21-0433 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:

6/16/2023

X Clayton J. Nix

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

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

[38] 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).

[39] 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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Merit Health Rankin, Prov. No. 25-0096, FYE 12/31/2017
Case No. 21-1789

Dear Messrs. Summar and Lamprecht,

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

Background:

A. ***Procedural History for Case No. 21-1789***

On April 9, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2017 ("FY 2017").

On September 27, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained six (6) issues:

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

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, Inc. ("CHS"). Accordingly, on April 13, 2022 and May 4, 2022, the Provider transferred Issues 2, 4, 5, and 6 to CHS CIRP groups. As a result, the sole remaining issues in this appeal are Issue 1 (DSH – SSI Percentage (Provider Specific)) and Issue 6 (the DSH – Medicaid Eligible Days).

[1] On April 13, 2022, this issue was transferred to Case No. 20-0997GC.
[2] On April 13, 2022, this issue was transferred to Case No. 19-2620GC.
[3] On April 13, 2022, this issue was transferred to Case No. 20-1336GC.
[4] On May 4, 2022, this issue was transferred to Case No. 20-1334GC.

On May 5, 2022, the Provider filed its preliminary position paper and promised that the listing of the specific Medicaid Days in dispute was "being sent under separate cover." Similarly, on August 30, 2022, the MAC filed its preliminary position paper.

On June 27, 2022, the MAC filed a Jurisdictional Challenge requesting that the Board dismiss Issues 1 and 3. On February 12, 2023, the MAC filed a Final Request for Medicaid Eligible Days.

Notably, the Provider has not filed a response to the Jurisdictional Challenge or the Request for Medicaid Eligible Days listing and the time for doing so has elapsed. 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.[5] 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."

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

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

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

The Provider transferred Issue 2 – DSH SSI Percentage (Systemic Errors) – to the CIRP Group under 20-0997GC, on April 13, 2022. The group issue in Case No. 20-0997GC reads, in part:

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

[5] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[6] Issue Statement at 1 (Sept. 27, 2021).

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.[7]

On May 5, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

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

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

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published

[7] Group Issue Statement, Case No. 20-0997GC.

> 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).[8]

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which shows that the amount in controversy for the issue is $12,686. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 20-0997GC.

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final 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.[9]

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

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[8] Provider's Preliminary Position Paper at 8-9 (May 5, 2022).
[9] Jurisdictional Challenge at 6-7 (June 27, 2022).
[10] *Id*. at 7-10.

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

Issue 3 – DSH Payment – Medicaid Eligible Days

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

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

Accordingly, the MAC requests that the Board dismiss Issue 3.

Provider's Jurisdictional Response

As discussed above, the Provider did not file a response to this jurisdictional challenge and the time for doing so has passed.

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to

[11] *Id*. at 4-6.
[12] *Id*. at 11-12.

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 Payment/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[13] The Provider's legal basis for its DSH 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)."[14] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[15]

The Provider's DSH Payment/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[16], the Board dismisses this aspect of the DSH 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, is pursuing that issue as part of the group under Case 20-0997GC (which it is required to do since it is subject to the mandatory CIRP group regulation). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[17] Provider is misplaced in referring to

[13] Issue Statement at 1.
[14] *Id.*
[15] *Id.*
[16] PRRB Rules v. 2.0 (Aug. 2018).
[17] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*,

Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0997GC.

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

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

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

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

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PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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

Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

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

Accordingly, *based on the record before it*,[21] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH – SSI (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH 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 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.

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[19] Last accessed February 24, 2023.
[20] Emphasis added.
[21] Again, the Provider failed to respond to the jurisdictional challenge and the Board must rule based on the record before it as explained in Board Rule 44.4.3.

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.[22]

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.[23]

Board Rule 7.3.1.2 (Nov. 2021) states:

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

[22] Individual Appeal Request, Issue 3.
[23] 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 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[24]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[25]

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

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

Similarly, with regard to position papers,[26] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[27] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

[25] (Emphasis added).

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

[27] (Emphasis added).

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

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[28]

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

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

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

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

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

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

[28] (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. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[29] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any specific days being identified in the position paper filing, the Board must assume that there are no actual days at issue and that the amount in dispute for this issue is $0.[30]

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 §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[31] The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[32]

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment – Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue and has abandoned the issue. As no issues remain pending, the Board hereby closes Case No. 21-1789 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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[29] (Emphasis added).

[30] The Board notes that the "estimated impact" included with the appeal request is just that an estimate and was based on an "estimated" 50 days. At the position paper stage of the appeal (particularly since as of the May 5, 2022 filing date), it had been 4+ years since the FY 2017 had ended and all Medicaid eligible days relating to that period should have been readily identifiable.

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

[32] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0076 (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).

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For the Board:

6/16/2023

X Clayton J. Nix

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Board Chair
Signed by: PIV

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Crestwood Medical Center (Provider Number: 01-0131)
FYE: 06/30/2015
Case Number: 18-1837

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 18-1837. The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 18-1837*

On March 16, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2015.

On September 12, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

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. Accordingly, on April 17, 2019, the Provider transferred issues to various CIRP group appeals, including Issue 2, DSH/SSI Percentage (Systemic Issues) to Case No. 18-0552GC, QRS CHS

[1] On April 17, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] This issue was withdrawn on March 30, 2021.
[3] On April 17, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On April 17, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

2015 DSH SSI Percentage CIRP Group. The last remaining issue is the DSH Payment/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 their Individual Appeal Request, The Provider summarizes its DSH Payment/SSI Percentage – Provider Specific issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

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

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

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

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include

[5] Issue Statement at 1 (Sept. 12, 2018).
[6] *Id*. at 2.

> all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[7]

Board Analysis and Decision:

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

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

1. *First Aspect of Issue 1*

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security

[7] Provider's Preliminary Position Paper at 8-9 (Apr. 29, 2019).

Income percentage in the Disproportionate Share Hospital calculation."[8] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[10]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[11], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 18-0552GC. 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.[12] Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary 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

[8] Issue Statement at 1.
[9] *Id.*
[10] *Id.*
[11] PRRB Rules v. 2.0 (Aug. 2018).
[12] 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).

is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[13]

[13] Last accessed February 24, 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."[14]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0552GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is, also, 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 and Issue 1 is dismissed.

****

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. 18-1837 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.

[14] Emphasis added.

Board Members Participating:

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For the Board:

6/23/2023

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Seven Rivers Regional Medical Center (Provider Number: 10-0249)
FYE: 09/30/2016
Case Number: 19-1454

Dear Messrs. Summar and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-1454. The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 19-1454*

On August 29, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2016.

On February 25, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

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

[1] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0173GC.
[2] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0175GC.
[3] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0198GC.
[4] This issue was withdrawn on February 22, 2022.
[5] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0159GC.
[6] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0197GC.

8. Uncompensated Care ("UCC") Distribution Pool[7]
9. 2 Midnight Census IPPS Payment Reduction[8]

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. Accordingly, on June 23, 2019, the Provider transferred issues to various CIRP group appeals, including Issue 2, DSH/SSI Percentage (Systemic Issues) which was transferred to Case No. 19-0173GC, CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group. The last remaining issue is the DSH Payment/SSI Percentage (Provider Specific) issue.

A. 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 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.[9]

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

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

[7] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0177GC.
[8] On June 23, 2019, this issue was transferred to PRRB Case No. 19-0185GC.
[9] Issue Statement at 1 (Feb. 25, 2019).

6. Covered days vs. Total days[10]

On October 9, 2019, the Provider submitted its preliminary position paper to the MAC. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This based on certain data from the State of Louisiana and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Louisiana and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[11]

MAC'S Contentions:

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision,

[10] *Id*. at 2.
[11] Provider's Preliminary Position Paper at 8-9 (Oct. 9, 2019).

> regardless of reimbursement impact. It should also be noted that the provider's fiscal year end is the same as the federal fiscal year end (September 30). The result of the Medicare computation based on the provider's fiscal year end would therefore be the same as the Medicare computation based on the federal fiscal year end.
>
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue. The MAC requests that the PRRB dismiss this issue consistent with other jurisdictional decisions.[12]

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.[13]

Provider's 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."[14] 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."[15]

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 2016, resulting from its understated SSI percentage due to errors of omission and commission."[16]

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

[12] Jurisdictional Challenge at 6-7 (May 31, 2019).
[13] *Id*. at 5-6.
[14] Jurisdictional Response at 1 (Jun. 27, 2019).
[15] *Id*. at 2.
[16] *Id*.

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

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

1. First Aspect of Issue 1

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

The Provider's DSH/SSI 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 Payment/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 PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 19-0173GC. 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

[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] PRRB 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 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).

reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-0173GC.

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

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

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

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

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

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

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

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 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 Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is, also, 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 and Issue 1 is dismissed. Further, the Provider's cost reporting period is the same as the Federal fiscal year, as both end on 9/30. Thus, realignment of the SSI percentage would result in no change.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC and there is no

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

final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 19-1454 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:

6/23/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Regional Hospital of Jackson (Prov. No. 44-0189)
FYE 05/31/2018
Case No. 21-1693

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background:

A. ***Procedural History for Case No. 21-1693***

On March 23, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2018.

On September 9, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH Payment/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

As the Provider is commonly owned/controlled by the health care chain, Community Health Services ("CHS"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). Accordingly, on March 30, 2021, the Provider transferred Issue 2 to a CHS CIRP group. As a result of this transfer, the sole remaining issues in this case are Issue 1, the DSH Payment/SSI Percentage (Provider Specific) issue, and Issue 3, the DSH Payment – Medicaid Eligible Days issue.

On May 5, 2022, the Provider filed its preliminary position paper. Similarly, on August 19, 2022, the Medicare Contractor filed its' preliminary position paper.

[1] On April 13, 2022, this issue was transferred to Case No. 21-1206GC.

On August 23, 2022, the Medicare Contractor filed a Jurisdictional Challenge requesting dismissal of Issue 1 because it duplicates Issue 2. Significantly, the Provider did not file a response to this jurisdictional challenge within the 30-day period allotted under Board Rule 44.4.3 (2021):

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

On November 14, 2022, the Medicare Contractor filed another Jurisdictional Challenge requesting that the Board dismiss Issue 3. On December 14, 2022, the Provider timely filed its response to that Challenge and its response ***only addressed the November 14, 2023 Jurisdictional Challenge***. 3On December 28, 2022, the Medicare Contractor filed its reply to the Provider's filing and restated its request that the Board dismiss Issue 3. The Provider did not respond to the MAC's Reply.

B. Description of Issue 1 in the Appeal Request and the Provider's Transfer of Issue 2 to Case No. 21-1206GC

In their Individual Appeal Request, Provider summarizes Issue 1, the DSH Payment/SSI Percentage (Provider Specific) issue, as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[2]

Provider described Issue 2, the DSH Payment/SSI Percentage (Systemic Errors) issue, which has been transferred to a CIRP group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records

[2] Issue Statement at 1 (Sept. 9, 2021).

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

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH SSI Percentage – to the CIRP group under Case No. 21-1206GC on April 13, 2022. The group issue in Case No. 21-1206GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/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:
> 7. Availability of MEDPAR and SSA records,
> 8. Failure to adhere to required notice and comment rulemaking procedures,
> 9. Fundamental problems in the SSI percentage calculation,
> 10. Not in agreement with provider's records,
> 11. Paid days vs. Eligible Days, and
> 12. 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 $19,553.

[3] *Id*. at 2.
[4] Group Issue Statement, Case No. 21-1206GC.

On May 5, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[5]

The ***only*** exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 2, which was simply refers back to the same "Estimated Impact" calculation included in the appeal request for Issue 1 showing an "Estimated Impact" of $19,553 for Issue 1. Again, this is the ***same*** amount and calculation that is listed as the amount in controversy for this Provider as a participant in Case No. 21-1206GC.

[5] Provider's Preliminary Position Paper at 8-9 (May 5, 2022).

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

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

In its August 23, 2022 Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[6]

Further, the MAC contends Issue 1 should be dismissed because the Provider failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25.[7]

In addition, the MAC argues the DSH Payment/SSI Percentage (Provider Specific) issue and the DSH Payment/SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[8]

Issue 3 – DSH Payment – Medicaid Eligible Days

In its second November 14, 2022 Jurisdictional Challenge, the MAC argued that the Provider abandoned the DSH Payment – Medicaid Eligible Days issue because it has not submitted a list of the Medicaid eligible days at issue in this case and has not fully addressed the issue in its May 5, 2022 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 29, 2022 (shortly after the Provider filed its May 5, 2022 preliminary position paper) and September 8, 2022.

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[6] Jurisdictional Challenge #1 at 6-7 (Aug. 23, 2022).
[7] *Id*. at 7-9.
[8] *Id*. at 4-6.

However, the Provider never responded to those requests. 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.[9]

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

2. <u>Provider's Jurisdictional Response</u>

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

The Provider did not file a response to the August 23, 2022 Jurisdictional Challenge regarding Issue 1, and the 30-day time frame to respond under Board Rule 44.4.3 has lapsed. Significantly, the Provider's December 14, 2022, response to the second

[9] Jurisdictional Challenge #2 at 4 (Nov. 14, 2022).

Issue 3 – DSH Payment – Medicaid Eligible Days

On December 14, 2022, the Provider timely responded to the Medicare Contractor's November 14, 2022 Jurisdictional Challenge regarding Issue 3. The Provider's position is that the due date for the listing of additional Medicaid eligible days was the Final Position Paper deadline.[10] The Provider goes on to argue that

> The MAC entirely overlooks that the [CMS] has recognized that "practical impediments" frequently impede a provider's ability to obtain the necessary support claiming additional Medicaid eligible days.
>
> . . .
>
> These impediments are related to the State eligibility matching being unavailable at this time due to a change in the State's matching vendor changes. Concurrent with this letter to the Board the Providers are sending to the MAC the listing of additional Medicaid eligible days for providers not impacted by practical impediment.[11]

The Provider goes on to say that they "have cured the sole defect on which the MAC relies, and the Board should deny the MAC's motion to dismiss."[12]

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 3, the Medicaid eligible days issue:

- "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, <u>including</u> 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."[13]

[10] Jurisdictional Response at 1 (Dec. 14, 2022).
[11] *Id*. at 2.
[12] *Id*.
[13] (Emphasis in original.)

- "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 3 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 Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 21-1206GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[14] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory

[14] Issue Statement at 1.

instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16]

The Provider's DSH Payment/SSI Percentage (Systemic Errors) issue in group Case No. 21-1206GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue in Case No. 21-1206GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6,[17] 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, is pursuing that issue as part of the group under Case 21-1206GC (which it is required to do since it is subject to the mandatory CIRP group regulation). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[18] 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. 21-1206GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 21-1206GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts 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,[19] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the

[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 2.0 (Aug. 2018).
[18] 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).
[19] There are no exhibit or citations to state records or examples of how SSI entitlement can be ascertained from state records.

merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

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

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[20]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new***

[20] Last accessed February 24, 2023.

> ***self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[21]

Accordingly, *based on the record before it*,[22] the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 21-1206GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH – SSI (Provider Specific) issue.

2. Second Aspect of Issue 1

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

B. DSH – Medicaid Eligible Days

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

[21] Emphasis added.

[22] Again, the Provider failed to respond to the first jurisdictional challenge pertaining to Issue 1 and its response to the second jurisdictional challenge relating to Issue 3 did not include any response to that first jurisdictional challenge. Accordingly, consistent with Board Rule 44.4.3, the Board must on the first jurisdictional challenged based on the record before it. In this regard, the Board notes that the Provider also failed to comply with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 by failing to properly develop the fact and merits of Issue 1 in its position paper filing (or in the alternative, failed to properly explain why it could not).

> Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[23]

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

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[24] 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.[25]

Board Rule 7.3.1.2 (Nov. 2021) states:

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

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

Notably, the Provider's preliminary position paper promised that it would be sending the 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"[26] 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

[23] Individual Appeal Request, Issue 3.
[24] Provider's Preliminary Position Paper at 8.
[25] Jurisdictional Response at 1.
[26] (Emphasis added).

when that change occurred and how it otherwise prevented it from obtaining the listing to include with its preliminary position paper. The Provider then promises that it would be finally, *at this late date*, filing in this case a redacted Medicaid Eligible days listing; however, the Provider never did so. Accordingly, it is clear that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[27]

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*.[28]

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

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

Similarly, with regard to position papers,[29] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[30] 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:

---

[27] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019, *available at*: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-11-1-2019-through-11-30-2019.pdf), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

[28] (Emphasis added).

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

[30] (Emphasis added).

> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[31]

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

[31] (Emphasis added).

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"[32] 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 did the Provider provide any explanation in its position paper filing as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2.[33] 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*"35 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 a year earlier when it filed its preliminary position paper on May 5, 2022 when it suggested a listing was imminent by promising 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

[32] (Emphasis added).
[33] Moreover, as discussed *supra*, the Provider's belated explanation provided in its December 14, 2022 response was wholly inadequate and still did not contain the *promised* Medicaid eligible days listing at this late date.

issue closed more than 5 years ago.[34] Similarly, the Provider's reference to the COVID-19 pandemic has no relevance because it pertained to filing deadlines (and not the content of those filings). Here, the Provider *voluntarily* complied with the deadline and, in fact, filed its preliminary position paper on September 1, 2021 ***without any reference to Alert 19 or the pandemic***.[35] To the extent COVID-19 affected the content of that filing, then it had an obligation to explain that pursuant to Board Rule 25.2.2. Further, the Provider has failed to explain, *at this late date*, how its *generic* reference to the COVID-19 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. The Board takes administrative notice that it has made similar dismissal in other cases in which QRS was the designated representative[36] as well as cases involving CHS providers.[37] 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 DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 21-1206GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment – Medicaid Eligible Days issue as the Provider

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[34] Note, the Board is *not* ruling that, had the provider done so, it would have accepted the listing at this late date. This situation is not before the Board and, as such, is not part of this ruling. Indeed, the fact that an alleged listing was available as of December 14, 2022 only highlights how extremely vague and inadequate the December 14, 2022 response is because the response represented on one hand that "at this time" an impediment existed but then on the other hand represents that a redacted listing was in fact available for filing on December 14, 2022. Again, the Provider's response is extremely vague and wholly inadequate.

[35] The Board takes administrative notice that the position paper filing in this case is virtually identical to that filed in other CHS cases with the same remaining two issues. Example cases are listed in *infra* note 37 and the Board similarly dismissed them.

[36] Examples of cases in which QRS was the designated representative and which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days at issue include, but are not limited to: Case No. 14-2674 (by 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).

[37] 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).

failed to meet the Board requirements for position papers for this issue and has abandoned the issue. As no issues remain pending, the Board hereby closes Case No. 21-1693 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:

6/26/2023

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

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Duplication of Issues & Related Transfers to CIRP Group***

St. Luke's East Lee's Summit Hospital (Provider Number: 26-0216)
FYE: 12/31/2018
Case Number: 22-1401

St. Luke's Health CY 2018 DSH SSI Unduly Narrow Definition of SSI Entitlement CIRP Group
Case Number: 23-0920GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the subject appeals in response to two transfer requests submitted on March 17, 2023 by Quality Reimbursement Services, Inc. ("QRS"/ "Representative") in the Provider's individual appeal. The background and pertinent facts with regard to these cases and the Board's Determination are set forth below.

Background & Pertinent Facts:

On **September 2, 2022**, QRS filed the individual appeal on behalf of St. Luke's East Summit Hospital ("St. Luke's") for FYE 12/31/2018. The individual appeal, which was subsequently closed on May 5, 2023, included the following issues:

(1) DSH SSI Percentage (SSI Numerator)
(2) DSH SSI Fraction Medicare Managed Care Part C Days[1]
(3) DSH Medicaid Fraction Medicare Managed Care Part C Days[2]
(4) IPPS Understated Standardized Payment Amount
(5) DSH SSI Unduly Narrow Definition of SSI Entitlement[3]
(6) DSH SSI & MCD Fractions -Medicare Managed Care Part C Days
(7) DSH SSI & MCD Fractions – Dual Eligible Days

[1] On October 26, 2022 Issue No. 2 was withdrawn.
[2] On October 26, 2022 Issue No. 3 was withdrawn.
[3] Issue Nos. 5, 6 and 7 were added to the appeal on October 14, 2022.

On **March 17, 2023**, QRS filed various transfer requests, including the transfer of the DSH SSI Percentage (SSI Numerator) (#1) and the DSH SSI Unduly Narrow Definition of SSI Entitlement (#5) to Case No. 23-0920GC, entitled the "St. Luke's Health CY 2018 **DSH SSI Unduly Narrow Definition of SSI Entitlement** CIRP Group."

After further review of the issue statements uploaded for the DSH SSI Percentage (SSI Numerator) and the DSH SSI Unduly Narrow Definition of SSI Entitlement issues, the Board notes that the issue statements are identical for both issues. According to both issue statements, the Provider is protesting CMS's "arbitrary" policy of excluding unpaid SSI days from the numerator of the Medicare fraction:

> Because CMS's treatment of unpaid Part A days as "days entitled to benefits under part A" was upheld by the Supreme Court in *Becerra v. Empire Health Found., for Valley Hosp. Med. Ctr.*, 597 S.Ct. June 24, 2022 WL 227680 (2022), CMS must apply the same interpretation of the word "entitled" in the context of "entitled to supplemental security income benefits." By doing so, CMS will necessarily have to widen the number of SSI status codes it treats as being "entitled to SSI benefits" to encompass not just the three codes CMS currently includes, but all codes that reflect eligibility for SSI benefits.

The issue statement in the CIRP group (*i.e.,* Case No. 23-0920GC), to which QRS is requesting the two issues be transferred, includes the same language related to the Supreme Court's *Empire* decision (regarding entitlement to paid and unpaid Part A days).[4]

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 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.

With regard to group appeals, the regulation at 42 C.F.R. § 405.1837(a) states:

(a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, only if—

(1) The provider satisfies individually the requirements for a Board hearing under §405.1835(a) or §405.1835(c), except for the $10,000 amount in controversy requirement in §405.1835(a)(2) or §405.1835(c)(3).

[4] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022).

(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

(3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.

The Board is bound by the statutes and regulations, including those governing CIRPs, specifically, 42 C.F.R. § 405.1837(b)(1)(i) which requires that commonly owned or controlled providers file single groups for the same issue occurring in the same year. Board Rule 12.2 also references the fact that, "[t]he matter at issue in the group appeal must involve a *single* question of fact or *interpretation* of law, regulation, or CMS Rulings that is common to each provider in the group."[5]

Accordingly, for purposes of St. Luke's and its appeal of the CY 2018 SSI Percentage (SSI Numerator) and the DSH SSI Unduly Narrow Definition of SSI Entitlement issues in Case No. 22-1401, the Board finds that St. Luke's appealed duplicate issues. This is evidenced by the fact that the uploaded issue statements for both Issues #1 and #5 are identical. In addition, the fact that the Provider requested the transfer of both issues to the ***same*** CIRP group further confirms that the issues are, actually, duplicative, which is in conflict with ***Board Rule 4.6****, which specifically prohibits "Duplicate Filings."*

Therefore, the Board hereby reinstates Case No. 22-1401 in order to dismiss the SSI Percentage (SSI Numerator) issue (#1) from Case No. 22-1401 as a prohibited duplicate of the DSH SSI Unduly Narrow Definition of SSI Entitlement Issue (#5). Consequently, the Board hereby denies the Provider's request to transfer the DSH SSI Percentage (SSI Numerator) issue (#1) from Case No. 22-1401 to Case No. 23-0920GC. Upon dismissal of the issue from Case No. 22-1401, no issues remain, and the case is closed. Finally, Participant #3 (St. Luke's) which was based on the transfer of the DSH SSI Percentage (SSI Numerator) issue is dismissed from Case No. 23-0920GC.

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 related cases.

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

FOR THE BOARD:

6/27/2023

X Kevin D. Smith, CPA

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

[5] Board Rules v 3.1 issued Nov. 1, 2021.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nan Chi, Director of Budget & Compliance
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: ***Board Decision***
Houston Methodist San Jacinto Hospital (45-0424)
FYE 12/31/2013
Case No. 17-0435

Dear Ms. Chi,

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 17-0435 in response to a jurisdictional challenge filed by the Medicare Contractor. The Board's decision is set forth below.

Background

A. Procedural History for Case No. 17-0435

On November 8, 2016, Houston Methodist San Jacinto Hospital ("Provider"), appealed a Notice of Program Reimbursement (NPR) dated May 12, 2016, for its fiscal year end ("FYE") December 31, 2013 cost reporting period. The Provider appealed the following 10 issues:[1]

- Issue 1: DSH Payment/Supplemental SSI Percentage (Provider Specific)
- Issue 2: DSH Payment SSI (Systemic Errors)[2]
- Issue 3: DSH SSI Fraction/Medicare Managed Care Part C Days[3]
- Issue 4: DSH SSI Fraction/Dual Eligible Days[4]
- Issue 5: DSH Medicaid Fraction/Dual Eligible Days[5]
- Issue 6: Whether Capital DSH was calculated correctly
- Issue 7: Whether the LIP amount was calculated correctly[6]
- Issue 8: Whether MAC used the correct LIP SSI percentage in Provider's IRF LIP adjustment[7]

[1] Provider's Request for Hearing, Tab 3, Appeal Issues (Nov. 8, 2016).
[2] Transferred to Case No. 17-1810GC.
[3] Transferred to Case No. 17-1808GC.
[4] Transferred to Case No. 17-1806GC.
[5] Transferred to Case No. 17-1807GC.
[6] Withdrawn on May 10, 2023.
[7] Withdrawn on May 10, 2023.

- Issue 9: Weighting of residents in calculation of DGME payment[8]
- Issue 10: Inclusion of certain residents in non-approved GME program[9]

As the Provider is commonly owned, it is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). On June 26, 2017, Issues 2-5 were transferred to CIRP group cases consistent with its obligations under § 405.1837(b)(1). On May 10, 2023, March 29, 2018 and August 16, 2022, the Provider withdrew Issues 7-8, 9, and 10, respectively. As a result of these transfers and withdrawals, only Issues 1 and 6 remain open in this case.

On April 19, 2018, the Medicare Contractor filed its first Jurisdictional Challenge over Issues 1, 7 and 8. On May 11, 2018, the Provider timely filed its response to the first Jurisdictional Challenge and this response did *not* include any exhibits.

On May 8, 2023, the Medicare Contractor filed its second Jurisdictional Challenge over the same issues, and indicated that this Jurisdictional Challenge is a replacement of the April 19, 2018 filing, and all facts and arguments contained within the second Jurisdictional Challenge supersede the previously filed one.[10] As noted above, the Provider withdrew Issues 7-8 on May 10, 2023, two days after the second Jurisdictional Challenge was filed.

On June 6, 2023, the Provider timely responded to the second Jurisdictional Challenge. Significantly, the response regarding Issue 1 is verbatim the same as what it filed as its May 11, 2018 response to the original Jurisdictional Challenge to Issue 1. Further, the Provider did *not* include any exhibits in support of its position.

On October 18, 2022, the Provider filed its final position paper ("FPP") which simply restated verbatim the issue statement in its appeal request and did *not* include any exhibits. Similarly, on November 17, 2022, the Medicare Contractor filed its FPP.

B. Descriptions of Issues 1 and 2 in the Appeal Request and the Provider's Participation in Case No. 17-1810GC

In its Individual Appeal Request, the Provider summarizes its DSH SSI Percentage (Provider Specific) issue (Issue 1) as follows:

> [T]he MAC [(Medicare Administrative Contractor)] did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[11]

[8] Withdrawn on March 29, 2018.
[9] Withdrawn on August 16, 2022.
[10] MAC's Jurisdictional Challenge at 2 n.8 (May 8, 2023).
[11] Provider's Request for Hearing, Tab 3

The Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[12] The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report are both flawed. The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage.[13]

The Provider also "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period," citing 42 U.S.C. § 1395(d)(5)(F)(i). The amount in controversy for this issue was listed as $39,819.[14]

Also in its Individual Appeal Request, the Provider describes the DSH SSI Percentage (Systemic Errors) issue (Issue 2) as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ["*Baystate*"] and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Paid days vs. Eligible days,
> 3. Not in agreement with provider's records,
> 4. Fundamental problems in the SSI percentage calculation,
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[15]

The amount in controversy for this issue was listed as $39,818.[16] This issue was transferred to the CIRP Group Case No. 17-1810GC on June 26, 2017. The CIRP Group Case No. 17-1810GC

[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id*.
[16] *Id.*

is entitled "*QRS Houston Methodist 2013 DSH SSI Percentage (Systemic Errors) CIRP Group"* and the Providers describe the group issue the exact same way as the issue is described above, in the instant appeal. In addition, in the group issue statement, the Providers included an additional paragraph that states:

> 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 required 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.

On October 18, 2022, the Provider filed its FPP in the instant case, which included a description of all of the issues in the appeal, including Issues 1 and 2, and which is ***identical*** to how their contentions were described in the Initial Appeal Request, and quoted above. While the Provider addressed all of the issues in its FPP, as discussed above, after transfers and withdraws, only Issues 1 and 6 remain open in this case.

MAC's Contentions in its Second Jurisdictional Challenge

The MAC first clarifies that, according to the Provider's appeal request, Issue 1 has two components: 1) SSI data accuracy; and 2) SSI realignment. With regard to the portion related to SSI data accuracy, the MAC contends that it is a duplicate of the issue under appeal in group Case No. 17-1810GC, and should be dismissed. In both issues, the Provider is disputing the accuracy of its SSI percentage, and is appealing an issue from a single determination in more than one appeal, which is not allowed under Board Rule 4.6.1.

With regard to the portion related to SSI realignment, the MAC contends that the Provider failed to note that it already requested SSI realignment and received a Notice of Correction of Program Reimbursement on November 1, 2019, which is attached as Exhibit C-5. The MAC asserts that the Provider has exhausted all available remedies for this issue, and therefore, the Board should dismiss this portion of the issue as well.

Finally, the MAC contends that the Provider failed to file a complete PPP with a fully developed narrative and all exhibits in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3. Further, the MAC asserts that in its FPP, the Provider contends that its SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in their calculation, yet offered no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Provider failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI percentage calculation

or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The MAC argues that the Provider has essentially abandoned the issue by failing to properly develop its arguments, to provide supporting documents or to explain why it cannot produce those documents, as required by regulations and Board Rules.

Provider's Response to the Second Jurisdictional Challenge

The Provider asserts that pursuant to Board Rule 8.1, some issues may have multiple components and each component must be appealed as a separate issue. In the instant case, the Provider asserts that Issues 1 and 2 represent different components of the SSI issue, so the Board should find jurisdiction over both issues.

The Provider maintains that the SSI Systemic Errors issue (Issue 2) addresses the various errors discussed in *Baystate* in CMS' calculation of the disproportionate payment percentage, which resulted in the MedPAR not reflecting all individuals who are eligible for SSI. The Provider contends that these systematic errors were the result of CMS' improper policies and data matching process, and this issue also covers CMS Ruling 1498-R.

The Provider contends that in the SSI Provider Specific issue (Issue 1), it is not addressing errors that result from CMS' improper data matching process but instead, it is addressing the various errors of omission and commission that do not fit into the "systematic errors" category. The Provider contends that, in *Baystate*, the Board also considered whether, independent of these systemic errors, Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. The Provider explains that, once these patients are identified, who are believed to be entitled to both Medicare Part A and SSI, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.

Board Analysis and Decision

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

A. Issue 1 -- DSH SSI Percentage (Provider Specific)

The analysis for Issue 2 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The first aspect of Issue 2—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Error) issue (Issue 2) that was transferred to CIRP Group Case No. 17-1810GC.

The DSH SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the [MAC] used the correct [SSI] percentage in the [DSH] calculation."[17] 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)."[18] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[19]

As the Provider is subject to the mandatory CIRP regulation, the Provider transferred the DSH SSI Percentage (Systemic Errors) issue to CIRP Group Case No. 17-1810GC. Significantly, the transferred issue also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue (Issue 1) in this appeal is duplicative of the DSH SSI Percentage (Systemic Errors) issue in Case No. 17-1810GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board 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, is pursuing that issue as part of the group under Case No. 17-1810GC (which it is required to do since it is subject to the mandatory CIRP group regulation). 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 is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider asserts that it "has ***specifically identified*** *patients* believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not systemic

[17] Provider's Request for Hearing, Tab 3
[18] *Id.*
[19] *Id.*
[20] Board Rules v. 1.3 (July 2015). At the time of the November 2016 filing of the appeal in this case, the July 1, 2015 version of the Board Rules were in effect.
[21] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006); *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

errors that have been previously identified in the *Baystate* litigation."[22] However, the Provider has not included anywhere in the record (whether as an exhibit to its response to the Jurisdictional Challenge or to its final position paper or to any other filing) a listing or other documentation identifying the alleged "specifically identified patients" which it asserts "are or may be specific to the Provider." Indeed, the Board suspects the Provider has not specifically identified any such patients because in the very next sentence of its response, the Provider states: *Once these patients **are identified***, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage."[23] Regardless, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed as Issue 2 and transferred to Case No. 17-1810GC. It is not sufficient to assert at this late stage of the appeal (*i.e.*, after final position papers have been filed and the merits of the parties' position is supposed to be fully developed therein) to simply assert without explanation that "[t]he Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio."[24]

Further, contrary to the Provider's assertion the Board in *Baystate* did not "consider[] whether independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI Ratio."[25] A review of the Board's decision in *Bastate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006) confirms that the Board did not consider non-systemic issues and the references to omitted records were identified and discussed as "systemic issues" covering five areas:

1. the omission of inactive SSI records at least through 1996;

2. the omission of SSI records relating to individuals who received a forced payment from an SSA field office;

3. the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;

4. the omission of SSI days associated with individuals whose benefits were granted or restored retroactively after SSA ran each year's tape; and,

5. the omission of individuals who were entitled to non-cash Federal SSI benefits.[26]

[22] Provider's Jurisdictional Response at 3 (emphasis added).
[23] Provider's Jurisdictional Response at 3 (emphasis added).
[24] Provider's Jurisdictional Response at 2.
[25] Provider's Jurisdictional Response at 2 (citation omitted).
[26] PRRB Dec. No. 2006-D20 at 23.

Regardless, the Provider has the burden to identify the alleged non-systemic issues and has failed to do so and a generic reference to *Baystate* does not satisfy that burden.

To this end, the Board also reviewed the Provider's FPP to see if it further clarified/developed Issue 1 consistent with its obligation under 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2). In this regard, the Board notes that its regulations and rules address the Provider's obligation to develop the merits of each issue and to provide all relevant supporting documentation. 42 C.F.R. § 405.1853(b) addresses position papers and specifies in pertinent part:

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe* ***to be decided by the Board*** *through a schedule applicable to a specific case or through general instructions*.[27]

As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Similarly, regarding position papers,[28] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[29] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

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

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

> Once the documents become available, promptly forward them to the Board and the opposing party.[30]

Here, the Provider failed to develop the merits of Issue 1 in its FPP and, in particular, failed to provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 17-1810GC, but instead restates *verbatim* the generic vague language in its appeal request without provide any support or explanation. For example, the Provider generically and vaguely asserts that "CMS has failed to include all patients entitled to SSI benefits in their calculation" but does not explain/describe how CMS failed, why that failure was provider specific as opposed to systemic, or identify any patients that were not included in the SSI fraction.[31] The Board further finds that the Provider's FPP failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. The Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the alleged "errors" in its FPP and include *all* exhibits; in fact, the Provider included the exact same language as its Appeal Request and did not further develop any arguments.

The Board recognizes that the Provider states in its FPP that it "*is seeking* SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[32] However, the Provider failed to comply with Board Rule 25.2.2 because it failed to: (1) specifically identify the missing documents; (2) explain why they remain unavailable; (3) state the efforts made to obtain the document; and (4) indicate when they will be available. The Provider's statement is vague in that it is unclear: (1) what "SSI data" it is seeking (*e.g.*, simply the MedPAR data set used to calculate the SSI percentage that CMS routinely provides to hospital, versus other information outside that MedPAR data set); (2) whether it has in fact submitted a request; and (3) if so, when that request was submitted and what the status is on that request.

Moreover, the Board notes that certain information on the data used for the Provider's SSI fraction is *readily available* and it is unclear whether and to what extent the Provider has reviewed this available information. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set***

[30] (Emphasis added.)
[31] To this end, the Provider failed to include any exhibits with its final position paper filing and the final position paper filing was simply a restatement of its appeal request.
[32] (Emphasis added.)

CMS uses t[33]o 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.[34]
> 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."[35]

It is unclear if the Provider has obtained the information readily available to it from CMS and used that data to compare to its own records.

Accordingly, *based on the record before it*, the Board finds that Issue 1 in the instant appeal and the group issue in Case No. 17-1810GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. The Board takes administrative notice that it has made similar dismissal in other Houston Methodist cases. Notwithstanding, Houston Methodist failed to sufficiently establish why and how Issue 1 is distinct from Issue 2 and not subject to the mandatory CIRP group regulation.

2. Second Aspect of Issue 1

With regard to 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—the MAC added Exhibit C-5 to the record with its FPP, which shows that the Provider requested SSI realignment to its cost reporting year of 12/31/2013, and that the request was granted by letter dated November 1, 2019. Therefore, the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting year is now moot, as this request was made and granted. For this reason, the Board dismisses this aspect of Issue 1.

B. Issue 6 -- Capital DSH Reimbursement

After the Board's determinations on the MAC's jurisdictional challenge, discussed above, the only remaining issue in this case is Issue 6. The Provider describes the remaining issue (Capital DSH Reimbursement) as asking the Medicare Contractor to incorporate the resolution of the

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[33] The following examples relate to Houston Methodist Hospital (Prov. No. 45-0358): (1) Board's Mar. 7, 2023 dismissal of SSI Provider Specific issue for FY 2010 from Case No. 16-2263; and (2) Board's Apr. 14, 2023 dismissal of SSI Provider Specific issue for FY 2011 from Case No. 17-1060. The representative on these cases is the ***same*** as that for this case.
[34] Last accessed June 7, 2023.
[35] (Emphasis added.)

DSH issues in this appeal to the determination of the Capital reimbursement amount. In its FPP, the Medicare Contractor agrees that any adjustments arising from the resolution of any of the applicable DSH issues should be incorporated into the calculation of the Capital DSH amount. The Medicare Contractor noted that the results of the operating DSH calculation on Worksheet E, Part A, will *automatically* flow to Worksheet L for the calculation of Capital DSH.

The Provider's description of Issue 6 relates ***only*** to the updating of the Capital DSH calculation. As any adjustment to the SSI Percentage/DSH calculation made for operating DSH on worksheet E Part A will automatically flow to worksheet L for the calculation of Capital DSH, as noted by the Medicare Contractor, Issue 6 (Capital DSH Reimbursement) does not present an issue that requires a Board determination. Specifically, this issue is not a dissatisfaction with a specific aspect of the final contractor determination, but rather, it is for the purpose of ensuring the specific aspects contested in the other issues in the appeal are calculated properly if those specific aspects of the final contractor's determination contested in those other issues are found by the Board to have been determined incorrectly. In other words, this issue is not a separate issue but rather is simply a component of the other issues because it pertains to the relief that the Provider is seeking relative to the other issues in the appeal if it were successful on one or more of those other issues. Accordingly, the Board finds that Issue 6 does not meet the content requirements for a request for a Board hearing on a final contractor determination under 42 C.F.R. § 405.1835(b)(2). Accordingly, the Board dismisses Issue 6.

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In summary, the Board hereby dismisses Issue 1, the SSI Percentage (Provider Specific) issue, from this appeal as it is duplicative of the group issue in Case No. 17-1810GC and the SSI realignment portion of the issue is now moot. Further, the Board dismisses Issue 6, which relates only to the updating of the Capital DSH calculation if other DSH issues in the appeal are found by the Board to have been determined incorrectly by the Medicare Contractor, as it does not meet the content requirements for a request for a Board hearing under the regulation. As no issues remain pending, the Board hereby closes Case No. 17-0435 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:

6/28/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR and Accelerated Hearing Determination***
Sentara Healthcare 2014 Bad Debt CIRP Group
Case No. 17-2226GC

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed Providers' June 7, 2023 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The decision of the Board is set forth below.

Issues in Dispute:

This CIRP group appeal was formed on September 12, 2017, was fully formed as of May 14, 2021, and contains eight (8) providers. The group is appealing the Medicare Contractor's treatment of the Providers' indigent bad debts. On November 7, 2022, the Providers' Representative submitted a Request for Accelerated Hearing and Status Conference. It claimed that the issue in this case is the exact same issue as the one presented in the same Providers' Fiscal Year ("FY") 2010-2013 appeals, which were decided by the Board in August 2020.[1] Following an adverse decision from the Administrator, the Providers appealed to the U.S. District Court for the District of Columbia ("D.C. District Court") and received an *unpublished* decision in their favor.[2]

On December 20, 2022, the Board denied the request for an accelerated hearing as premature, noting that, subsequent to the Board's prior decision for these Providers, CMS promulgated certain retroactive bad debt regulations which had not been briefed. One day later, on December 21, 2022, the Board issued a Critical Due Dates Notice requiring the Group's Preliminary Position Paper ("PPP") be filed by April 21, 2023, and the Medicare Contractor's be filed by August 21, 2023. On April 20, 2023, the Providers timely filed their PPP.

On June 7, 2023, filed a request for EJR or, in the alternative, for an accelerated hearing.[3] On June 12, 2023, the Medicare Contractor filed its response opposing the EJR request.

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[1] *Sentara Healthcare Bad Debt CIRP Grps. v. Palmetto GBA c/o Nat'l Gov't Servs., Inc.*, PRRB Dec. No. 2020-D17 (Aug. 26, 2020) ("PRRB Dec. 2020-D-17").
[2] *Sentara Hosps. v. Azar*, No. 20-CV-3771, 2022 WL 910514 (D.D.C. Mar. 29, 2022) ("*Sentara v. Palmetto*").
[3] Providers' Petition for EJR or Alternatively for an Accelerated Hearing (June 7, 2023) ("EJR Request").

The Medicare Contractor has not yet filed their PPP as it is not due until August 21, 2023.

Providers' Request for EJR and Accelerated Hearing:

The Providers' EJR Request argues that CMS is *collaterally estopped* from relitigating the merits of the indigent Medicare bad debt claims at issue in this case.[4] It asserts that the same issue in the instant appeal concerning *FY 2014* was already heard and decided by the Board, Administrator, and D.C. District Court ***for FYs 2010-2013***. In that case, the Providers issued bad debt policies that used certain financial information obtained from Equifax to make indigence determinations, but the Medicare Contractor disallowed the costs, claiming that the Providers' themselves were required to assess patients assets, income, liabilities, and expenses without relying on Equifax data.[5] The Board majority ultimately found that the use of Equifax data generally ***complied*** with the Providers' *then-in-effect* indigent bad debt policy, but it concluded that it was also required to consider income from a married patient's spouse and, thus, only allowed indigent bad debts where that was done.[6]

The Administrator subsequently issued a decision disallowing all of the Providers' bad debts.[7] This decision was appealed to the D.C. District Court, which found the Administrator's decision was not supported by substantial evidence.[8] It found that the Providers properly considered patient resources,[9] made its own indigence determinations,[10] and was only required to document the method used to determine indigence, which was done.[11] The D.C. District Court ultimately set aside the Administrator's decision and ordered CMS to reimburse the Providers for indigent bad debts for FYs 2010-2013.[12]

The Providers note that they are all under the common ownership or control of the same corporation at issue in the above-referenced CIRP group case. Similarly, all of the Providers had bad debts disallowed based on the use of Equifax data to verify indigency.[13] The Providers are requesting EJR because they believe the Board has jurisdiction over the issue raised in the appeal, but does not have the authority to apply issue preclusion as sought by the Providers in their PPP. In the alternative, the Providers request the Board set an accelerated hearing date in light of the favorable decisions from the Board and the D.C. District Court.[14] The Providers maintain that issue preclusion applies in this case, foreclosing the Medicare Contractor from relitigating this issue which has already been litigated and decided, but also acknowledges that the Board lacks the authority to apply issue preclusion because it is an equitable doctrine. Accordingly, since the

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[4] *Id.* at 1.
[5] *Id.* at 5 (citing PRRB Dec. 2020-D17 at 4, 8).
[6] *Id.* (citing PRRB Dec. 2020-D17 at 22-24).
[7] *Healthcare Bad Debt CIRP Grps. v. Medicare Contractor – Palmetto GBA c/o Nat'l Gov't Servs.*, 2020-D17 (CMS Adm'r Oct. 22, 2020).
[8] *Sentara v. Palmetto* at *4-9.
[9] *Id.* at *6.
[10] *Id.* at *8.
[11] *Id.*
[12] *Id.* at *9.
[13] EJR Request at 9.
[14] *Id.* at 12.

Board is without the authority to decide whether the agency is collaterally estopped from relitigating the merits of the issue under appeal, the Providers contend EJR is appropriate.[15]

Regarding the alternative request for an accelerated hearing, the Providers note that their PPP addressed the applicability of the new bad debt regulations. They note that the regulations related to indigent bad debts issues raised in this case do not apply retroactively, but prospectively. Thus, they contend that the new regulations are not material to this case.[16]

Medicare Contractor's Response to the EJR Request:

On June 12, 2023, the Medicare Contractor filed a timely[17] Response to Provider's Request for Expedited Review. It notes that the Provider is *not* challenging the propriety of a statute, but to impose a federal district court's reasoning with respect to prior fiscal years to the present appeal. It argues that the Board does, in fact, have the authority to decide the factual questions raised in the appeal. It also suggests that the fact that the Board conducted a previous hearing encompassing the same parties and same issue indicates that the issue is, in fact, appropriate for a Board hearing. The Medicare Contractor also argues that indigence determinations are fact specific and that it is entitled to challenge these determinations as a matter of due process. Based on the foregoing, the Medicare Contractor requests the Board deny the request for EJR

Relevant Law:

A. Jurisdiction

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [18]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[19]

[15] *Id.* at 12-16.
[16] *Id.* at 17.
[17] Board Rule 42.4 (Nov. 2021) requires the Medicare Contractor to file a response opposing an EJR Request within five (5) business days of the filing of the EJR Request (*i.e.*, no later than June 14, 2023 in the instant case).
[18] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[19] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

While the Medicare Contractor opposes the EJR request, it has not filed any jurisdictional challenge or noted any jurisdictional impediments for any providers since the receipt of the initial appeal and the Provider's EJR Request.[20]

B. Expedited Judicial Review

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (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.

1. Res Judicata: Issue Preclusion/Collateral Estoppel

The term "*res judicata*" encompasses two distinct doctrines – claim preclusion and issue preclusion.[21] The Providers have invoked the doctrine of issue preclusion (also known as collateral estoppel) and this doctrine "precludes a party from relitigating an issue actually decided in a prior case and necessary to the judgement."[22]

The Board is an administrative forum which has specific, and limited, authority defined by 42 U.S.C. § 1395oo and the implementing regulations at 42 C.F.R. Part 405, Subpart R. The regulation at 42 C.F.R. § 405.1867 defines the scope of the Board's authority:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

The Board is not granted general powers of equity. Congress has dictated in the Board's governing statute that "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[23]

Similarly, the Secretary promulgated regulations at 42 C.F.R. Part 405, Subpart R to govern proceedings before the Board. None of the regulations promulgated thereunder confer on the

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[20] On June 14, 2023, the auditor for Palmetto GBA filed a Jurisdictional Review document noting that there are no jurisdictional impediments for any Providers in this case.
[21] *Lucky Brand Dungarees, Inc. v. Marcel Fashions Group, Inc.*, 140 S. Ct. 1589, 1594-1595 (2020).
[22] *Id.* (citations omitted).
[23] 42 U.S.C. § 1395oo(d).

Board the authority to prohibit relitigation of an issue across fiscal years. The Board notes that Rule 8(c)(1) of the Federal Rules of Civil Procedure ("FRCP") lists *res judicata* as an affirmative defense and the Secretary has not required the Board to apply the FRCP except in certain limited discovery circumstances specified in 42 C.F.R. Part 405, Subpart R. Additionally, neither the Board's decisions nor those of the Administrator have general controlling precedence.[24]

The Board's governing statute specifies that "[p]roviders shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider . . .) that it is without authority to decide the question."[25] The Secretary promulgated the regulation at 42 C.F.R. § 405.1842 to implement this statutory provision. In particular, § 405.1842(a)(1) states that EJR may be granted when there is "a legal question *relevant to a specific matter at issue* in a Board appeal if the Board has jurisdiction to conduct a hearing on the matter . . . ***and*** the Board determines it lacks the authority to decide the legal question (***as described in § 405.1867*** of this subpart, which explains the scope of the Board's legal authority)."[26]

2. Hearing Request

Requests for an accelerated hearing are governed by Board Rule 31.1:

> When a party is fully prepared to present its case and is unable to administratively resolve the case, it may request that the hearing for the case be set at the earliest possible date (or within a specified range of dates). The request shall provide a status report on the case (*see* Rule 29) and demonstrate that:
>
> 1. The case has no impediments to a hearing (such as outstanding motions or discovery requests); and
>
> 2. The documentation exchange between the parties is ***complete*** (including but not limited to providing copies of any expert reports and underlying documentation to the extent an expert is being called as a witness).

The request must also state whether the non-moving party concurs. If granted, the Board may establish such deadlines or impose such conditions as may be appropriate.

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[24] *See* PRM 15-1 § 2927(e) (entitled "Nonprecedential Nature of the Administrator's Review Decision").
[25] 42 U.S.C. § 1395oo(f)(1).
[26] (Emphasis added.)

Decision of the Board:

A. Board's Decision Regarding the EJR Request

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (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.

Based on the authorities discussed above, and as the Group Representative acknowledges,[27] the Board finds that Congress did not confer power to the Board to apply issue preclusion in the manner requested. The Providers have requested Board grant EJR over the substantive issue appealed (*i.e.*, the disallowance of their indigent bad debts) because the Board lacks the authority to decide whether the agency is collaterally estopped from relitigating the merits of the issue. Section 405.1842(a)(1) limits the Board's authority to grant EJR to legal questions that are "relevant to a specific matter at issue" and are "described in § 405.1867." The Board recognizes that the *Sentara v. Palmetto* decision discusses what appears to be the same indigent bad debt issue for the Providers' bad debt policy for different fiscal years; however, that the decision was issued by a U.S. federal district court and is *unpublished* and, as a result, the decision has no *general* controlling precedence. Regardless, it is not necessarily clear that the case before the Board necessarily involves the same facts and circumstances.[28]

Furthermore, the legal question of issue preclusion as posed does not itself entail a legal *challenge* to or legal question under "the provisions of Title XVIII of the Act and regulations issued thereunder" and, as such, necessarily falls *outside the scope of the Board's authority* to grant EJR in the first instance (as well as the scope of the Board hearing proceedings).[29]

Accordingly, the Board declines to apply the doctrine of *res judicata* or grant EJR in this appeal on the question of issue preclusion as presented and hereby ***denies*** the request for EJR because the issue preclusion is outside the scope of EJR consideration and the Board has the authority to resolve and decide the legal and factual disputes presented in this case.[30] Finally, the Board

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[27] EJR Request at 16.
[28] *See infra* note 30.
[29] Rather, FRCP Rule 8(c)(1) lists *res judicata* is an affirmative defense and the FRCP is not part of "the provisions of Title XVIII of the Act and the regulations issued thereunder. The proper forum for Sentara to raise an affirmative defense is in federal district court should this appeal reach federal district court. In this regard, the Board again notes that the Secretary has not required the Board to apply the FRCP except in certain limited discovery circumstances specified in 42 C.F.R. Part 405, Subpart R
[30] Indeed, even if the Board were to consider issue preclusion and/or EJR of that issue, it would be premature because, not only has the Medicare Contractor opposed that request, this is a fact-intensive case and the Medicare Contractor has yet to file its preliminary position paper. As a result, the full nature of the parties' dispute (including the common facts and circumstances for FY 2014 which are not necessarily the same as those for FYs 2010 to 2013) has not yet been fully developed. In this regard, the Board notes that its review is *de novo*.

notes that it previously addressed *res judicata* and issue preclusion in PRRB Dec. No. 2020-D20 and that the Board's decision here is consistent that in PRRB Dec. No. 2020-D20.[31]

B. Board's Decision Regarding the Accelerated Hearing Request

The Board denies the request for an accelerated hearing because it did not comply with Board Rule 31.1 and it continues to be premature. The request did not state whether the Medicare Contractor concurs, and the Board notes that the Medicare Contractor objected to the Providers' previous request for an accelerated hearing. Furthermore, it appears to be premature since it is not clear that the documentation exchange between the parties is complete or that there are no impediments to a hearing. In particular, the Board notes that the case has not been briefed by both parties: the Medicare Contractor has not filed its PPP and has until August 21, 2023 to do so.

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The Board ***denies*** the Providers' EJR request and request for accelerated hearing. 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.[32]

Board Members Participating:

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

FOR THE BOARD:

6/29/2023

X Clayton J. Nix

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

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, FSS

[31] UHS 2006-2009 Medicare Bad Debts Still At Agency CIRP Group v. Novitas Solutions, Inc. PRRB Dec. No. 2020-D20 (Aug. 31, 2020).

[32] *See also* 42 C.F.R. § 405.1842(h)(2)(i). This regulation states, in pertinent part: "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." In these instances, as the Board may not conduct any further proceedings, the Board requires notice of the lawsuit from the representative so that the Board may close the case/issue pending remand from the appeal. This expectation is consistent with Board Rule 1.3 and ensures that the Board and the opposing party do not unnecessarily waste any resources.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
23-1230GC Main Line Health CY 2019 Capital DSH CIRP Group
23-1097G Bass, Berry & Sims, PLC CY 2018 Capital DSH Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 26, 2023 consolidated request for expedited judicial review ("EJR")[1] in the above-referenced group appeals.[2] The decision with respect to EJR is set forth below.

Issue

In these group cases, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

[1] The consolidated request for EJR also included two other cases, Case No. 23-0477GC, Penn State Health CY 2019 Capital DSH CIRP Group, and Case No. 23-0790GC, Mount Sinai Health System CY 2018 Capital DSH CIRP Group, for which the Board issued a decision on June 15, 2023 under separate cover.
[2] Main Line Health is a parent organization with multiple hospitals and is subject to the mandatory CIRP group regulations at 42 C.F.R. § 405.1837(b)(1) as it relates to the common issue in Case No. 23-1230GC for the year 2019. As Main Line Health designated the CIRP group fully formed, they are prohibited from pursuing this same issue for the same year in any other appeal (whether as part of an individual provider appeal or a group appeal) as explained in § 405.1837(e)(1): "When the Board has determined that a group appeal brought under paragraph (b)(1) . . . 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."
[3] Request for Expedited Judicial Review, 1 (May 26, 2023) ("Request for EJR").

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] These cases focus on the capital IPPS.

A. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

B. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[10]

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[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited June 27, 2023) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

The DSH adjustment provided under operating IPPS is ***not*** at issue in these cases. The DSH adjustment is relevant because certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment, the Secretary adopted for purposes of capital IPPS.

C. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e*., separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22, 1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

The Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME)

[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited May 31, 2023).
[16] 56 Fed. Reg. 43358 (Aug. 30, 1991).

> exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to $((1 + DSHP)^{0.4176} - 1))$, where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive

[17] *Id.* at 43369-70 (emphasis added).
[18] *Id* at 43377.

> disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1, 1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l)(ii) of the regulations.[20]

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.* at 43377.

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] *Id.* (Emphasis added.)

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.
>
> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.[24]

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[25]

[24] *Id.*
[25] *Id*. at 43452-53.

2. Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[26] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[27]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific

[26] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).
[27] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added).

comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.

****

Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area.*

Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

> Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.
>
> ****
>
> We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[28]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http://www.nal.usda.gov/orph or from the U.S. Department of

[28] 65 Fed. Reg. 47054, 47087-89 (Aug. 1, 2000).

> Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
>
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[29]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", it would appear that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban <u>or</u> rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[30]

[29] *Id*. at 47048.
[30] *Id.* at 47047 (Bold and underline emphasis added.)

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[31] Specifically, § 401 specifies that, beginning with FY 2004, all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[32] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[33]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[34] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—

[31] Pub. L. 108–173
[32] 69 Fed. Reg. 48916, 49026-27 (Aug. 11, 2004).
[33] *Id.*
[34] 69 Fed. Reg. 48916 (Aug. 11, 2004).

(A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or

(B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine; Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.

(C) The term *rural area* means any area outside an urban area.

(D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.

(2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.

(3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.

(4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[35]

[35] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes of receiving payment under § 412.63(a)*, in an urban area."[36] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[37]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.

[36] (Emphasis added.)
[37] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

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> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
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>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[38]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[39] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[40]

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[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[39] of the Department of Health and Human Services.
[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[41]

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[42]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[43]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

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[41] *Id.*
[42] *Id.*
[43] *Id.*

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[44]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as Added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed by the U.S. District Court for the District of Columbia ("D.C. District Court") in the 2021 *unpublished* decision for *Toledo Hosp. v. Becerra* ("*Toledo*"),[45] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[46]

In *Toledo*, D.C. District Court outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[47] The Court also noted how Congress

[44] (Bold emphasis added.)
[45] 2021 WL 4502052 (D.D.C. 2021).
[46] *Id.* at *8 (citations omitted).
[47] *Id.* at *2.

enacted legislation in 1999[48] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into an urban labor market area for the purposes of fixing its wage index.[49] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[50] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[51]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in an arbitrary and capricious manner.[52]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[53] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[54]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

    - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[55]

    - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[56]

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[48] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.
[49] *Toledo* at *3.
[50] *Id.* at *3-4.
[51] *Id.* at *4.
[52] *Id.* at *5.
[53] *Id.* at *6-8.
[54] *Id.* at *11.
[55] *Id.*
[56] *Id.*

- "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp*., 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[57]

- "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[58]

Notwithstanding these findings, the D.C. District Court declined to vacate 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[59] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[60]

Providers' Request for EJR

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[61]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[62]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[63] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act .

[57] *Id.*
[58] *Id.* at *11-12.
[59] *Id.* at *12.
[60] *Id.*
[61] Request for EJR at 7.
[62] *Id.* at 1, 7.
[63] *See id.* at 7.

. . [and] payment for direct GME are made under section 1886(h) of the Act."[64] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[65]

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[66]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[67] Further, the Providers contend that the Secretary has conceded the issue prospectively in his most recently proposed inpatient prospective payment rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii), as follows:

> For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, *and before October 1, 2023*, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[68]

Thus, the Providers contend, if the rule is finalized, for discharges on or after October 1, 2023, "hospitals reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining eligibility for capital DSH payments" and therefore will be eligible for capital DSH.[69] However, the Providers explain that "while the Fiscal Year 2024 [] proposed rule would revise 42 C.F.R. § 413.20(a)(1)(iii) in accordance with the *Toledo* decision for discharges on or after October 1, 2023, such changes, even if finalized, would not impact the Providers as the years at issue in this request are outside the scope of the proposed amendments."[70]

The Providers further contend that since the Board is bound by the regulation being challenged,[71] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[72]

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[64] *Id.* at 8, citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005).
[65] *Id.*
[66] *Id.* at 8-9.
[67] *Id.* at 9, 11-12.
[68] *Id.* at 9-10, *citing* Medicare Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals Policy Changes and Fiscal Year 2024 Rates, 88 Fed. Reg. 26,658, 27,307 (May 1, 2023) (emphasis added).
[69] *Id.* at 10, *citing* 88 Fed. Reg. at 27,058.
[70] *Id.* at 11-12, *citing* 88 Fed. Reg. at 27,058-59.
[71] *See* 42 C.F.R. § 405.1867.
[72] Request for EJR at 10, 12.

Board Decision

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

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[73] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[74] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board (hereinafter the "claim-specific dissatisfaction requirement"), again, for cost reports beginning on or after January 1, 2016. As all of the participants in these two cases have fiscal years that began after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise these group appeals have filed appeals involving fiscal years ending in 2018 or 2019. All of the participants have appealed from an original NPR or from the failure of the Medicare contractor to issue an NPR within twelve (12) months from the submission of the cost report or amended cost report.

Based on its review of the record, the Board finds that all of the providers in these group appeals timely filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, or more than 12 months after the submission of their amended cost report and a final determination has not yet been issued under 42 C.F.R. § 405.1835(c)(1). The Providers each appealed the issue in the EJR request, and the Board is not precluded by regulation or statute from reviewing the issue. Further, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3) in the cases at issue.

[73] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[74] *Id.* at 70555.

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

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

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

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.[75]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[76] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[77]

On May 31, 2023, Federal Specialized Services ("FSS"), on behalf of the Medicare Contractors, filed a response to the Providers' Request for EJR and on June 2, 2023, FSS filed a revised response indicating that it would be filing a substantive claim challenge for two providers in each of these two cases. On June 2 and 6, 2023, the Medicare Contractors filed Substantive Claim Challenges for a total of four providers in the two cases, and asserted that an appropriate claim was not made by those four providers. Specifically, in Case No. 23-1230GC, the group consists of two providers, Main Line Hospital Bryn Mawr Campus (39-0139), and Main Line Hospital Lankenau (39-0195), and the Medicare Contractor asserts that neither of the two providers properly included an appropriate cost report claim for the appealed item in dispute.[78] In Case No. 23-1097G, the group consists of four providers, and the Medicare Contractor asserts that two of the providers, Sentara RHM Medical Center (49-0004) and New Hanover Regional Medical Center (34-0141), did not include an appropriate cost report claim for the disputed issue.[79]

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[75] (Bold emphasis added.)
[76] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[77] *See* 42 C.F.R. § 405.1873(a).
[78] MAC's Substantive Claim Challenge in Case No. 23-1230GC (June 6, 2023).
[79] MAC's Substantive Claim Challenge in Case No. 23-1097G (June 2, 2023).

Those four providers filed a combined response to the Medicare Contractor's Substantive Claim Challenges on June 16, 2023. The four providers indicated that they did not file a protest item to 42 C.F.R. § 412.320(a)(1)(iii) (the regulation that is in dispute), and instead, they self-disallowed the issue based on the Medicare Contractors being bound by that regulation.[80]

Since a party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[81] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made by the four Providers in these appeals. However, the Providers have conceded that they did not comply with § 413.24(j) and, as such, this noncompliance is *undisputed*. Therefore, pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that the four Providers failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2), and notes that this is undisputed as the Providers/Group Representative have acknowledged this fact.

C. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

While the four Providers admit that they did not protest the capital DSH issue on their cost reports, the Providers assert that the self-disallowance regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are invalid insofar as these regulations would limit the Board's authority to order payment to providers that have not claimed a particular cost on their cost report as an allowable cost or as a protested amount. The Group Representative requested a second EJR in this particular case over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the capital DSH issue discussed above).[82]

In the EJR request, the Providers argue that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board. The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131, 140 (2016). They argue that the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[83]

With regard to the Board's jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services . . .) that it is without authority to decide the question." The Providers note that while the validity of these regulatory provisions was not at issue when the Providers filed their appeal, the Medicare Contractor raised

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[80] Provider's Response to the Substantive Claim Challenge and Second EJR Request at 2 (June 16, 2023) ("Provider's Response and EJR Request").
[81] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[82] Provider's Response and EJR Request at 1, 5. The Medicare Contractors did not file a response to the second EJR request, and the time required to do so has now passed. Board Rule 42.4.
[83] *Id.* at 5-9.

this issue in its Substantive Claim Letters, and the Board's rules entitle the Providers to respond, including in the context of an EJR filing, citing Board Rule 44.5.2. Further, the Providers argue that because the Medicare Contractor argues that the substantive claim regulatory provisions prevent the four Providers from receiving additional reimbursement for the capital DSH payment, the validity of these substantive claim regulatory provisions stems from the Providers' appeal of the capital DSH regulation and is integral to the resolution of the capital DSH issue.[84]

Per 42 C.F.R. § 405.1842(a)(1), "a provider [has] the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in these group appeals. Since there is no factual dispute regarding the Providers' lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Providers are seeking. Consequently, EJR is appropriate on this issue and the Board grants the Providers' EJR request on this challenge.[85]

D. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over both the capital DSH issue and the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 for the subject years and that the Providers in these group appeals are entitled to a hearing before the Board;

2) The Providers' appealed cost reports with cost reporting periods beginning after January 1, 2016, and it is undisputed that the following four Providers failed to include "an appropriate claim for the specific item" that is the subject of the appeal, as required under 42 C.F.R. § 413.24(j):

    a. In Case No. 23-1230GC: (1) Main Line Hospital Bryn Mawr Campus (Provider No. 39-0139), and (2) Main Line Hospital Lankenau (Provider No. 39-0195),

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[84] *Id.* at 11

[85] The Board recognizes that this question relates only to 2 of the 4 participants in Case No. 23-1097G and, as such, does not apply to the full *optional* group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to those 2 participants in Case No. 23-1097G.

b. In Case No. 23-1097G: (3) New Hanover Regional Medical Center (Provider No. 34-0141), and (4) Sentara RHM Medical Center (Provider No. 49-0004);

3) Based upon the Providers' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), as well as the assertions regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid ***and*** whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR request for the capital DSH issue and the subject years. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for this issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in these two group appeals, the Board hereby closes them and removes them from the Board's docket.

Board Members Participating:

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

FOR THE BOARD:

6/29/2023

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Wilson Leong, FSS