DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

David Johnston
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215-4291
Via: DJohnston@ebglaw.com

RE: ***Notice of Dismissal***
Holzer Medical Center (Provider Number: 36-0054)
FYE: 6/30/2016
Case Number: 19-1698

Dear Mr. Johnston:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Holzer Medical Center's ("Provider's") Individual Appeal Request in Case No. 19-1698 on February 27, 2019. The four issues in this appeal are: (1) Dual Eligible Medicare Advantage Days – Medicaid Fraction, (2) Dual Eligible Medicare Advantage Days – Medicare Fraction, (3) SSI Percentage, and (4) Uncompensated Care.

The Provider failed to appear at its August 1, 2023, hearing for this case.

The Board may dismiss an appeal due to a Provider's failure to appear for a scheduled hearing pursuant to Board Rule 30.2 (Nov. 1, 2021), which states that "[e]xcept for good cause beyond a provider's control, the Board will dismiss a case if the provider fails to appear at the hearing." Further, Board Rule 41.2 provides that the Board may dismiss a case on its own motion upon failure of the provider to comply with Board procedures, citing 42 C.F.R. § 405.1868, and upon failure to appear for a scheduled hearing. The regulation at 42 C.F.R. § 405.1868 provides, in pertinent part:

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

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Provider failed to appear at the hearing, and the Provider has not shown good cause as to why this case should not be dismissed. Accordingly, the Board hereby dismisses Case No. 19-1698 with prejudice.

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.

For the Board:

8/1/2023

X Kevin D. Smith, CPA

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

Board Members:

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Joseph Bauers, Esq. Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)

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Via Electronic Delivery

Ms. Elizabeth Elias
Hall, Render, Killian, Heath & Lyman, P.C.
500 N. Meridian St., Suite 400
Indianapolis, IN 46204

RE: ***Board Decision***
Ascension Health 2013 Medicare/Medicaid Fraction Part C Days CIRP Group
Case Number: 15-2783GC

Dear Ms. Elias,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced appeal and dismisses three providers. The decision of the Board is set forth below.

Pertinent Facts:

The Common Issue Related Party ("CIRP") Group appeal was established on June 19, 2015, appealing the Medicare/Medicaid Fraction Part C Days. Three Providers in the group have appealed revised Notices of Program Reimbursement ("NPR") that were issued as the result of requests for realignment of the SSI percentage from the federal fiscal year to the cost reporting period.

Seton Northwest Hospital (Provider Number 45-0867) was added to the appeal via direct add request on February 14, 2018, and is appealing from a revised NPR dated August 25, 2017. The Provider was previously issued a Notice of Reopening on February 15, 2017:

> To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year. A request for approval will be submitted to CMS.

Similarly, Seton Medical Center Austin (Provider Number 45-0056) was added to the appeal via direct add on February 16, 2018, and is also appealing from a revised NPR dated August 29, 2017. The Provider was previously issued a Notice of Reopening on February 15, 2017:

> To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year. A request for approval will be submitted to CMS.

Last, Seton Medical Center Hays (Provider Number 67-0056) was added to the appeal via direct add on February 20, 2018, and is appealing from a revised NPR dated August 29, 2017. The Provider was previously issued a Notice of Reopening on February 15, 2017:

> To update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year. A request for approval will be submitted to CMS.

All three Providers have adjustments on their audit adjustment reports stating: "To adjust the SSI percentage per CMS."

Board Decision:

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

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

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

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

[1] 42 C.F.R. § 405.1889(b).

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

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

The Board finds that it does not have jurisdiction over the Part C Days issue in this appeal for Seton Northwest Hospital, Seton Medical Center Austin, or Seton Medical Center Hays because these Providers' revised NPRs were issued as a result of the Providers' SSI Realignment request, and did not make adjustments related to the Part C days issue. Thus, the provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopenings in this case were a result of the Providers' request to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year end. More specifically, the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[4] In other words, the determination was only being

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[2] (Emphasis added).
[3] 42 C.F.R. § 405.1889(b)(1).
[4] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42

reopened to include the realigned SSI percentage and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process that the Provider is trying to appeal (much less revise any of the Part C days included in the underlying month-by-month data). Since the only matter specifically revised in Seton Northwest Hospital, Seton Medical Center Austin, or Seton Medical Center Hays' revised NPRs were the adjustments related to realigning the SSI percentage from federal fiscal year to the Provider's fiscal year, the Provider does not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for the Part C Days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[5]

The Board finds that it does not have jurisdiction over Seton Northwest Hospital, Seton Medical Center Austin, or Seton Medical Center Hays'[6] revised NPR appeals and therefore dismisses the Providers from the appeal. The remaining Providers in PRRB Case 15-2783GC will be remanded pursuant to CMS Ruling 1739-R under separate cover.

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

Board Members Participating:

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

For the Board:

8/1/2023

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
John Bloom, Noridian Healthcare Solutions (J-F)

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

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

[6] The Board notes that Seton Medical Center Hays' original NPR appeal remains pending in the group.

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Via Electronic Delivery

Kimberly Jones
HCA Healthcare, Inc.
2000 Health Park Dr., 2-North
Brentwood, TN 37027

RE: ***Dismissal of Part C Days Issue***
Good Samaritan Hospital (Provider Number 05-0380)
FYE: 1/31/2013
Case Number: 22-0274

Dear Ms. Jones:

The Provider Reimbursement Review Board ("Board") has reviewed the Part C Days issue in the above-captioned appeal. The Board's determination is laid out below.

Pertinent Facts

Good Samaritan Hospital ("Good Samaritan") filed an individual appeal with the Board on December 16, 2021, appealing a Notice of Program Reimbursement (NPR) dated June 25, 2021. Good Samaritan appealed two issues:

- Dual Eligible Days
- Medicare Part C Days for DSH under Ruling 1739-R

The appeal request contained the following issue statement regarding the appealed Part C Days issue:

> Whether the days related to patients who were enrolled in Medicare Advantage plans under Part C days of the Medicare statute ["Part C days"] were properly treated in the Medicare disproportionate share hospital ["DSH"] calculation.

Good Samaritan further clarifies:

> Audit adjustments #4 & 21 improperly omits Part C days in computing the fraction reflecting the percentage of inpatients who were entitled to medical assistance under an approved State plan [the "Medicaid fraction"]. Additionally, Part C days were incorrectly included in the Medicare Part A /SSI fraction in audit adjustment #21.

In reviewing the case, the Board notes that Good Samaritan is part of the HCA Healthcare, Inc. chain. The Board notes that HCA established a Common Issue Related Parties ("CIRP") group known as HCA 2013 DSH – Medicare Advantage Plan Days on October 16, 2014 (Case No. 15-0150GC). The group issue was identified as follows:

> The common issue in this group appeal concerns the treatment in the calculation of the Medicare disproportionate share hospital ("DSH") payment of inpatient days for Medicaid-eligible patients who were enrolled in a Medicare Advantage plan under part C of the Medicare statute. These days were excluded from the numerator of the Medicaid fraction that is used to calculate the DSH payment for the cost reporting periods at issue…The Providers contend that all of the Medicaid eligible Medicare Part C days at issue must be counted in the numerator of the Medicaid fraction and that part C days must be excluded in their entirety from the SSI fraction.

On September 17, 2021, the case was renamed HCA Pre 10/1/2013 DSH Medicare Advantage Plan Days CIRP Group to distinguish from HCA's Post 10/1/2013 CIRP group. The Provider Representative identified Case No. 15-0150GC as fully formed on October 7, 2020. The case was subsequently remanded to the Medicare Contractor under CMS Ruling 1739-R on September 24, 2021.

Board Determination

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> *Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.*[1]

Board Rule 19.2 Mandatory CIRP Groups reflects the regulation:

> *Mandatory CIRP group appeals must include **all** providers eligible to join the group that intend to appeal the disputed common issue for the year(s) covered by the CIRP group.*

The regulation at 42 C.F.R. § 405.1837(e)(1) requires that the group provider provide notice that the group is fully formed and complete.[2] Once the group is certified as complete, restrictions are placed on the ability to pursue the issue for additional providers under common ownership:

[1] 42 C.F.R. § 405.1837(b)(1).
[2] 42 C.F.R. § 405.1837(e)(1).

> *When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.*[3]

Once again, Board Rule 19.2 reflects the regulation:

> *As stated in 42 C.F.R. § 405.1837(e)(1), "[w]hen the Board has determined that a [CIRP group] 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 fall within the calendar year(s) covered by the group appeal.*

As Good Samaritan was part of the same common ownership as the providers in Case No. 15-0150GC, for the same issue (Part C Days), and for the same fiscal years, the Board finds that the appeal of the Part C Days issue in Case No. 22-0274 violates the provisions of 42 C.F.R. § 405.1837(b)(1) and (e) and Board Rule 19.2 Accordingly, the Board dismisses the Part C Days issue from Case No. 22-0274.

The case remains open as the Dual Eligible Days issue remains in the appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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

FOR THE BOARD

8/2/2023

X Kevin D. Smith, CPA

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

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

[3] *Id.*

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Via Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Lorraine Frewert
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Dismissal of Duplicate Appeal***
St. Joseph HS 2006 Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group
Case Number: 17-1987GC

Dear Mr. Chinea and Ms. Frewert:

The above-referenced common issue related party ("CIRP") group appeal for St. Joseph Health System ("St. Joseph") includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* and *after* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the Common Owner of this group, St. Joseph, has already been granted EJR for the issue under appeal, and for this specific Fiscal Year. As such, the above CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

The Board received the Group Representative's Request for Hearing dated August 3, 2017, to establish the above mentioned CIRP group. The CIRP group appeal request contained the following issue statement regarding the appealed Part C Days issue:

> Whether CMS' inclusion of Medicare Part C Days in the SSI Ratio was proper?[1]

In reviewing the documentation, the Board notes that the common owner of this group had already been granted Expedited Judicial Review ("EJR") for the Part C days issue for this specific fiscal year, in another group case. Specifically, an EJR request in Case No. 10-0051GC was granted on December 10, 2018, over whether Part C patients are "entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI [] fraction and excluded from the Medicaid fraction numerator or vice-versa."[2]

[1] Provider's Group Appeal Request, at Tab 2 (Aug. 3, 2017).
[2] EJR Determination (Dec. 10, 2018), PRRB Case No. 10-0051GC, et al.

Provider St. Joseph Hospital (Prov. No. 05-0006) is the only Provider included in the instant appeal. This Provider was also in Case No. 10-0051GC, the case that was granted EJR on December 10, 2018, appealing from the same cost year. Given the EJR determination issued in Case No. 10-0051GC, these cases are duplicative and violate the CIRP regulations.

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[3]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[4] Once the group is certified as complete, restrictions are placed on the ability to pursue the same issue for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[5]

Pursuant to the CIRP regulations at 42 C.F.R. 405.1837(b)(1) and (e), processing of the EJR on the Board's part dictates that the group is considered fully formed; Any additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[6] As PRRB Case No. 17-1987GC was part of the same common ownership, for the same issue (Part C Days), and for the same fiscal year, any provider within this case is in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

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[3] 42 C.F.R. § 405.1837(b)(1).
[4] 42 C.F.R. § 405.1837(e)(1).
[5] *Id*.
[6] *See* 42 C.F.R. § 405.1837(e) ("[w]hen the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.").

Furthermore, the Board notes that the EJR requests for which the Board granted EJR (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Part C DSH issue, i.e., both the Medicare and Medicaid fractions.

Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[7] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[8] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[9] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses the DSH Part C Days issue from PRRB Case No. 17-1987GC because the issue was disposed of through the EJR of Case No. 10-0051GC, and because Case No. 17-1987GC violated the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e).

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

Board Members Participating:

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

For the Board:

8/2/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, FSS

[7] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[8] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[9] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

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Via Electronic Delivery

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

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

Toyon Associates CY 2009 Inclusion of Medicare Part C Days in SSI Ratio III Group
Case Number: 18-1805G

Specifically: Enloe Medical Center (Provider Number 05-0039) and
Stanford Health Care – Valleycare (Provider Number 05-0283)

Dear Mr. Chinea:

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

Procedural History:

On August 28, 2018, Toyon Associates, Inc. ("Toyon") filed the "Toyon Associates CY 2009 Inclusion of Medicare Part C Days in SSI Ratio III Group" under Case No. 18-1805G. The optional group was designated to be fully formed on August 29, 2019, and includes three participants:

- Enloe Medical Center (Provider Number 05-0039) ***(RNPR)***
- San Francisco General Hospital (Provider Number 05-0228) (Original NPR) and
- Stanford Health Care-Valleycare (Provider Number 05-0283) ***(RNPR)***

The individual appeals for the two respective Providers that filed from receipt of a RNPR each included the DSH - Inclusion of Medicare Part C Days in the SSI Ratio ("Part C Days") issue and in each case, Toyon requested the transfer of the Part C Days issue to the subject optional group.

Pertinent RNPR Facts for Enloe Medical Center

- RNPR Date: 1/12/2018
- Audit Adjustment Nos.:
  #1: Completed cost reporting forms & pages in accordance w/ current regulations
  #4: Adjust SSI percentage to agree w/ revised ratio based on the provider's FYE
  #5: Adjust allowable DSH percentage to account for revised SSI percentage
  #7: Adjust the SSI percentage to agree with the revised ratio based on the provider's FYE
- Provider transferred from Case No. 13-2819 on Aug. 28, 2018. Case No. 13-2819 was closed on June 9, 2020.

Pertinent RNPR Facts for Stanford Health Care -Valleycare

- RNPR Date: 6/27/2017
- Audit Adjustment Nos.:
  #1 Completed cost reporting forms & pages in accordance w/current regulations
  #4 Revise SSI Ratio using CMS Calculation -based on the provider's FYE instead of FY
  #5 Amend allowable DSH percentage to account for the change in the SSI Ratio
  #7 Revise SSI Ratio using CMS Calculation based on the provider's FYE instead of FY
- Provider transferred from Case No. 18-0386 on Aug 28, 2018. Case No. 18-0386 was closed on March 25, 2019.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final contractor determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the

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

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

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

The Board has determined that it does not have jurisdiction over the Part C Days issues that were appealed from the RNPRs for Enloe Medical Center (Prov. No. 05-0039) and Stanford Health Care–Valleycare (Prov. No. 05-0283). The Board finds that the RNPRs for these two Providers

[1] 42 C.F.R. § 405.1889(b).
[2] (Emphasis added).

were issued as a result of SSI Realignment requests, and the RNPRs did not adjust the Part C Days issue.[3] Thus, the Providers do not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] The reopenings for these Providers were a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to their individual cost reporting fiscal year ends. Based on the audit adjustments associated with the RNPR under appeal for each Provider, it is clear that the revision to the SSI percentage was adjusted only in order to realign it from a federal fiscal year to the providers' respective fiscal year. More specifically, the determinations were only reopened to include the realigned SSI percentage where the SSI percentage was realigned from the federal fiscal year to the providers' fiscal year, *and* the realignment process (as described in the Federal Register) does not change any of the underlying data that is gathered on a month-by-month basis since CMS does not rerun the data matching process in order to effectuate a realignment.[5] In other words, the determinations were only being reopened to include the realigned SSI percentages and CMS' realignment process (as described in the Federal Register) does ***not*** entail re-running of the data matching process (much less revise any of the Part C days included in the underlying month-by-month data).[6] Since the only matters specifically revised in the RNPRs for Enloe Medical Center and Stanford Health Care–Valleycare were the adjustments related to realigning the SSI percentages from federal fiscal year to the provider fiscal year, the respective Providers do not have a right to appeal under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) for

[3] Although Toyon did not provide copies of the respective Providers' Request to Reopen, nor copies of the Medicare Contractor's Notices of Reopening, it is clear from the audit adjustment reports that the RNPRs were issued as a result of the Providers' requests for Realignment.
[4] 42 C.F.R. § 405.1889(b)(1).
[5] CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). However, CMS does not utilize or re-run the data match process when it issues a realigned SSI percentage. Rather, when CMS conducts the realignment process, all of the underlying data which has already been gathered on a month-by-month basis through that data matching process remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it based on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).
[6] *See supra* n. 5.

the Part C Days issues. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[7]

Conclusion

The Board finds that it lacks jurisdiction over Enloe Medical Center (Prov. No. 05-0039) and Stanford Health Care–Valleycare (Prov. No. 05-0283) that appealed from RNPRs because the issue under appeal in the group was not specifically revised in the RNPRs which were the basis for the respective Providers' appeals. 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 case.

The Board will issue a remand pursuant to CMS Ruling 1739-R for the remaining group participant, San Francisco General Hospital (Prov. No. 05-0228), under separate cover.

Board Members:

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

For the Board:

8/3/2023

X Kevin D. Smith, CPA

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Dismissal of Duplicate Appeal***
SRI Adventist 2007 DSH Medicaid Ratio Part C Dual Eligible CIRP
Case Number: 13-3935GC

Dear Mr. Janowski and Ms. Frewert:

The above-referenced common issue related party ("CIRP") group appeal for Adventist includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the Common Owner of this group, Adventist, has already been adjudicated via 1739-R Remand for the issue under appeal, and for this specific Fiscal Year. As such, the above CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

The Board received the Group Representative's Request for Hearing dated September 30, 2013, to establish the above mentioned CIRP group. The CIRP group appeal request contained the following issue statement regarding the appealed Part C Days issue:

> *Whether the Intermediary's adjustment to the computation of disproportionate share that excludes certain dual eligible patient days where the patient has MedicareChoice + coverage (Part C coverage) with Medi-Cal secondary coverage in the numerator of the Medicaid patient utilization percentage used to complete the patient Disproportionate Share reimbursement percentage in the disproportionate share settlement, is consistent with 42 CFR Regulation §412.106, 42 C.F.R Regulation Section §412.320, 42 U.S.C. Section 1886(d)(5)(f) and Provider Reimbursement Manual Instructions.*

In reviewing the documentation, it was noted that the common owner of this group had already appealed the Part C days issue for this specific fiscal year, in another group case. Specifically, PRRB Case 13-0764GC Campbell Wilson-Adventist 2007 SSI Part C Days CIRP Group was filed prior to this appeal being filed, with several of the same participants. The Board previously remanded that appeal on April 21, 2021, to the Medicare Contractor, pursuant to CMS Ruing 1739-R. This case includes a similar issue statement.[1]

> *Hanford Community Medical Center ("Hanford") contends that the Centers for Medicare and Medicaid Services ("CMS") via the Medicare Administrative Contractor, systematically overstated SSI days used for the Hanford's DSH SSI payment. More specifically, Hanford contends that CMS systematically overstated or included beneficiaries who were not entitled to Part A as required as they were enrolled in Medicare Advantage Part C. As a result, this overstatement or inclusion of the Medicare Advantage Part C has resulted in reimbursement not in accordance with the regulatory guidance as mandated under 42 C.F.R. § 412.106(b).*

In addition, the Board notes that a third CIRP group for Adventist 2007 Part C days was previously dismissed as a duplicate, GNP/Adventist Health 2007 DSH Medicaid Ratio-Medicare Part C Days CIRP Group, on August 29, 2022.

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> *Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.*[2]

Board Rule 4.6.2 also addresses duplicate filings:

> *A provider may not appeal an issue from a single final determination in more than one appeal.*

Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[3] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid

[1] Group Appeal Request (Model Form B – Attachment II) (February 15, 2013).
[2] 42 C.F.R. § 405.1837(b)(1).
[3] 746 F.3d 1102, 1108 (D.C. Cir. 2014).

fraction.[4] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[5] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

Thus, PRRB Case No. 13-3935GC and 13-0764GC are duplicate appeals and PRRB appeal 13-0764GC was previously disposed of through the 1739-R Remand of the appeal to the Medicare Contractor. Case No. 13-3935GC is a duplicate appeal of the same Part C DSH issue in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) and the PRRB Rules involving duplicate appeals, at 4.6.1.

As such, the Board dismisses the DSH Part C Days appeal PRRB Case No. 13-3935GC because the issue was disposed of through the 1739-R Remand of Case No. 13-0764GC, and because Case No. 13-3935GC violates the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e) as well as the duplicate appeal PRRB Rule 4.6.2.

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:

8/3/2023

X Kevin D. Smith, CPA

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

cc: Wilson Leong, FSS

[4] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Brent Wilson
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RE: ***Board Decision***
Crossroads Community Hospital (Prov. No. 14-0294)
FYE 12/31/2016
Case No. 20-0337

Dear Mr. Wilson:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 20-0337 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 20-0337*

On May 2, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On October 28, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is commonly owned/controlled by the health care chain, Quorum Health Services ("Quorum"), 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 May 21, 2020, the Provider transferred Issues 2 and 5 to Quorum CIRP groups. As a result of these transfers, the

[1] On May 21, 2020, this issue was transferred to PRRB Case No. 19-1503GC.
[2] On May 21, 2020, this issue was transferred to PRRB Case No. 19-1504GC.

remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage (Provider Specific) issue) and Issue 3 (the DSH – Medicaid Eligible Days issue) and Issue 4 (UCC Distribution Pool).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

The 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 June 24, 2020, 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 (June 30).

[3] Issue Statement at 1 (Oct. 28, 2019).
[4] *Id*. at 2.

> 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]

MAC's Contentions

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

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

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[6]

[5] MAC's Motion to Dismiss, Ex. C-1 at 8-9 (Mar. 1, 2023).
[6] Jurisdictional Challenge at 6-7 (Sept. 18, 2020).

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

Issue 3 – DSH – Medicaid Eligible Days

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

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

Issue 4 – UCC Distribution Pool

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

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

Provider's Jurisdictional Response

The Provider did not file a response to the Jurisdictional Challenge or the Motion to Dismiss and the 30-day time frame to respond under Board Rule 44.4.3 has lapsed. Accordingly, as a result of the waiver of their right to respond, the Board must rule based on the record before it.

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

[7] *Id*. at 5-6.
[8] Motion to Dismiss at 4-5.
[9] Jurisdictional Challenge at 10.
[10] *Id*. at 11.

it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 19-1503GC.

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/SSI Percentage (Systemic Errors) issue in group Case No. 19-1503GC 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. 19-1503GC. 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

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

and, to that end, is pursuing that issue as part of the group under Case 19-1503GC which it is required to do since it is a common issue subject to the mandatory CIRP rules at 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[15] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has *failed* to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1503GC in its appeal request and failed to respond to the Jurisdictional Challenge.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1503GC, 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 claims that SSI entitlement can be ascertained from State records but fails to explain how or establish what those alleged records show, or identify any days in dispute based on those records (much less explain how the State record issue would be provider specific and not subject to the CIRP group rules and not already part of the CIRP group to which it transferred the systemic issue). Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

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

[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).

> 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.[16] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[17]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1503GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the

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

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.[18]

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.[19]

Board Rule 7.2 (B) states:

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

[18] Individual Appeal Request, Issue 3.
[19] MAC's Motion to Dismiss, Ex. C-1 at 8.

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2 (B).

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[20]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[21]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) 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,[22] Board Rule 25.2 (A) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[23] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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[20] *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.

[21] (Emphasis added).

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

[23] (Emphasis added).

Similarly, consistent with that regulation, Board Rule 25.2 (B) provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.[24]

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

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

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

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

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

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

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

[24] (Emphasis added).
[25] (Emphasis added).

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 (B). Indeed, without any days identified in the position paper filing, the Board assumes that there are no days and $0 actually in dispute for this issue.

The Board finds that the 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 (A) and 25.2 (B) 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.[26]

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

C. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).[27]

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[28]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

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[26] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

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

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

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[29] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[30] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[31] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[32]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[33]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[34] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[35] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying

[29] 830 F.3d 515 (D.C. Cir. 2016).
[30] 89 F. Supp. 3d 121 (D.D.C. 2015).
[31] 830 F.3d 515, 517.
[32] *Id.* at 519.
[33] *Id.* at 521-22.
[34] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[35] *Id.* at 506.

methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[36]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[37] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[38] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[39] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[40] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[41]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[42]

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

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[36] *Id.* at 507.
[37] 514 F. Supp. 249 (D.D.C. 2021).
[38] *Id.* at 255-56.
[39] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[40] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[41] *Id.*
[42] *Id.* at 262-64.

estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[43] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[44] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[45]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[46] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[47] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[48] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[49] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[50] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[51]

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

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2016 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2016. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

Decision

Accordingly, based on the record before it, the Board hereby dismisses:

1. The DSH Payment/SSI Percentage (Provider Specific) issue from appeal because it is duplicative of the issue in PRRB Case No. 19-1503GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and the Provider failed to properly develop the issue to establish it as a separate and distinct issue;

2. The DSH – Medicaid Eligible Days issue because the Provider failed to meet the Board requirements for preliminary position papers for this issue as described at 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25; and

3. The UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation.

In making these dismissals, the Board notes that the Provider failed to respond to the relevant Jurisdictional Challenges and Motions to Dismiss. 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:

8/4/2023

X Clayton J. Nix

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

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

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RE: ***Dismissal of Duplicate Appeal***
16-1784GC Sutter Health 2006 DSH SSI Part C CIRP Group

Dear Mr. Jaeger and Ms. Frewert:

The above-referenced appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has determined that the instant appeal is duplicative of PRRB Case No. 20-1608GC, and therefore, must be dismissed. The decision of the Board is set forth below.

Background

A. Background for Case No. 16-1784GC

On June 3, 2016, Sutter Health forme PRRB Case No. 16-1784GC entitled "Sutter Health 2006 DSH SSI Part C – CIRP Group" with six (6) Providers. Additional providers were subsequently added this appeal. The appeal currently contains 14 Providers and it has not yet been designated as complete:

- Alta Bates Medical Center (Prov. No. 05-0305) was added to the appeal via transfer from Case No. 13-1229 on June 3, 2016, and appealing from a Notice of Program Reimbursement ("NPR") dated October 19, 2012.
- California Pacific Medical Center – Davies (Prov. No. 05-0008) was added to the appeal via transfer from Case No. 13-0503 on June 3, 2016, and appealing from a NPR dated August 10, 2012.
- Sutter Medical Center – Sacramento (Prov. No. 05-0108) was added to the appeal via transfer from Case No. 13-1205 on June 3, 2016, and appealing from a NPR dated September 21, 2012.
- Sutter Medical Center – Santa Rosa (Prov. No. 05-0291) was added to the appeal via transfer from Case No. 13-0801 on June 3, 2016, and appealing from a NPR dated August 21, 2012.

- Summit Medical Center (Prov. No. 05-0043) was added to the appeal via transfer from Case No. 13-1230 on June 3, 2016, and appealing from a NPR dated October 9, 2012.
- Eden Medical Center (Prov. No. 05-0488) was added to the appeal via transfer from Case No. 13-0699 on May 22, 2017, and appealing from a NPR dated August 21, 2012.
- Sutter Auburn Faith Hospital (Prov. No. 05-0498) was added to the appeal via transfer from Case No. 16-2522 on July 19, 2018, and appealing from a Revised NPR ("RNPR") dated March 31, 2016.
- California Pacific Medical Center – Pacific Campus (Prov. No. 05-0047) was added to the appeal via transfer from Case No. 16-2104 on July 25, 2018, and appealing from a NPR February 23, 2016.
- St. Lukes Hospital (Prov. No. 05-0055) was added to the appeal via transfer from Case No. 16-2527 on August 30, 2018, and appealing from a NPR dated February 23, 2016.
- Sutter Solano Medical Center (Prov. No. 05-0101) was added to the appeal via transfer from Case No. 16-2531 on September 24, 2018, and appealing from a RNPR dated March 28, 2016.
- Sutter Amador Hospital (Prov. No. 05-0014) was added to the appeal via transfer from Case No. 16-2532 on December 12, 2018, and appealing from a RNPR dated March 29, 2016.
- Sutter Delta Medical Center (Prov. No. 05-0523) was added to the appeal via transfer from Case No. 16-2451 on December 20, 2018, and appealing from a RNPR dated March 28, 2016.
- Memorial Medical Center (Prov. No. 05-0557) was added to the appeal via transfer from Case No. 16-2533 on January 14, 2019, and appealing from a RNPR dated March 29, 2016.
- Memorial Medical Center (Prov. No. 05-0557) was added to the appeal via transfer from Case No. 16-2533 on June 26, 2020, and appealing from a RNPR dated June 29, 2016.

B. Background for Case No. 20-1608GC

On November 20, 2019, Sutter Health formed PRRB Case No. 20-1608GC entitled "Sutter Health CY 2006 DSH Medicaid Ratio Dual Eligible Part C Days CIRP Group." When Sutter Health filed the group appeal request to establish Case No. 20-1608GC, Sutter Health made the following certification regarding the provider used to establish the group:

- "I hereby certify the group issue filed under this appeal is not pending in any other appeal for the same period for the same provider, nor has it been adjudicated, withdrawn or dismissed under any other PRRB appeal. The Provider has been notified that this issue is being transferred to the appeal case number [pending]. The Provider agrees with the transfer."

On November 13, 2020, Sutter Health confirmed with the Board that the group appeal was ***fully formed***. On March 22, 2021, the Board issued the Notice of Group Full Formation and Critical Due Dates in Case No. 20-1608GC.

Subsequently, on December 16, 2021, Sutter Health requested a change of representative to Toyon Associates, Inc. ("Toyon"), which the Board acknowledged on December 17, 2021. On

December 17, 2021, Toyon filed Sutter Health's preliminary position paper for this case as required by the Critical Due Dates Notice

Following the fully formation of the group, there are only five (5) participants in the appeal:

- St. Lukes Hospital (Prov. No. 05-0055) was added to the appeal via transfer from Case No. 16-2527 on May 4, 2020, and appealing from a RNPR dated March 29, 2016.
- Sutter Auburn Faith Hospital (Prov. No. 05-0498) was added to the appeal via transfer from Case No. 16-2522 on May 21, 2020, and appealing from a RNPR dated March 31, 2016.
- Memorial Medical Center (Prov. No. 05-0557) was added to the appeal via transfer from Case No. 16-2533 on June 26, 2020, and appealing from a RNPR dated June 29, 2016.
- Sutter Amador Hospital (Prov. No. 05-0014) was added to the appeal via transfer from Case No. 16-2532 on July 15, 2020, and appealing from a RNPR dated March 29, 2016.
- California Pacific Medical Center (Prov. No. 05-0047) was added to the appeal via transfer from Case No. 16-2104 on November 4, 2020, and appealing from a NPR dated February 23, 2016.

The following issue statement used to establish Case No. 20-1608GC clearly request both the exclusion of Part C Days from the SSI fraction and the inclusion of those Part C days involving dual eligbles in the numerator of the Medicaid fraction:

> The Provider contends CMS' new interpretation of including Medicare Dual Eligible Part C Days in the SSI ration issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision. The Secretary did not validly change her interpretation of the DSH calculation prior to FY 2013, and because there is no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations, the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. The Provider's position is supported by the federal district court decision in *Allina Health Services, et a1, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services* (Civil Action No, l0-ì463 (RMC)). The Provider maintains the position all Medicare Dual Eligible Part C Days should be included in the Medicaid patient day ratio of the Medicare DSH and LIP payment calculations.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to 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.

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.[1]

Subsection (e)(1) requires that the group provider provide notice that the group is fully formed and complete.[2] *Once the group is certified as complete* (as was done here in Case No. 20-1608GC), restrictions are placed on the ability for additional providers under common ownership:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is ***fully formed***, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal***.[3]

Importantly, the Board notes PRRB Case No. 20-1608GC clearly encompasses the ***complete*** Part C DSH issue, *i.e*., both the Medicare and Medicaid fractions (as shown in the above issue statement for this case). Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[4] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[5] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[6] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

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[1] 42 C.F.R. § 405.1837(b)(1).
[2] 42 C.F.R. § 405.1837(e)(1).
[3] *Id*.
[4] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[5] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[6] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

As discussed above, Sutter Health indicated that Case No. 20-1608GC was *fully formed* on November 20, 2019, therefore pursuant to 42 C.F.R. § 405.1837(e)(1), "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." Since PRRB Case No. 16-1784GC is part of the same common ownership (Sutter Health), for the same issue (Part C Days and all of the 6 initial providers used to establish Case No. 16-1784GC had the same issue statement as that for Case No. 20-1608GC), and for the same fiscal years, any providers within this case are in violation of 42 C.F.R. § 405.1837(b)(1) and (e)(1), and thus must be dismissed.

As such, pursuant to its authority under 42 C.F.R. §§ 405.1837(e)(1) and 405. 1868(a)-(b) (and consistent with Board Rules 4.6, 4.7.2.1, 19, 19.2, 19.5, 20, and 41.2), the Board hereby dismisses the DSH Part C Days issue from PRRB Case No. 16-1784GC because the issue is duplicative of the issue in the ***fully formed*** Case No. 20-1608GC and, as such, is in violation of the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e)(1). In designating Case No. 20-1608GC fully formed, Sutter Health abandoned Case No. 16-1784GC.[7] The Board will remand Case No. 20-1608GC pursuant to CMS Ruling 1739-R under separate cover.

The Board hereby closes the group appeal under Case No. 16-1784GC and removes it from the Board's docket. Review of this determination may available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/7/2023

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Dylan Chinea, Toyon Associates, Inc.

[7] In this regard, the Board notes the last filing made by Sutter Health in Case No. 16-1784GC was on June 26, 2020 (a transfer request). This was 4 months ***prior to*** Sutter Health certifying on November 13, 2020 that Case No. 20-1608GC was *fully formed*, and nearly a 1 ½ years ***prior to*** the filing of the preliminary position paper ***and*** the Rule 20 certification. Here Rule 20 was applicable because Toyon certified that all of the participants in Case No. 20-1608GC were fully populated in OH CDMS (*i.e.*, there were no other providers outside of those listed in OH CDMS). *See* Board Rule 20 (stating "If all the participants in a fully-formed group are populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a hard copy of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.").

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***
Corewell Health CY 2018 Capital DSH CIRP Group
Case No. 23-0698GC

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 7, 2023 consolidated request for expedited judicial review ("EJR")[1] in the above-referenced group appeal.[2] The decision with respect to EJR is set forth below.

Issue

In this group case, 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 one other group case, PRRB Case No. 22-1254GC, Hartford Health FFY 2019 Capital DSH CIRP Group, for which the Board will issue a decision under separate cover.
[2] Corewell 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. 23-0698GC for the year 2018. As Corewell 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 (July 7, 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]

---

[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 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)

[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 Aug. 1, 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

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

> 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 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]

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

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.
>
> *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.

[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).

(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.

(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 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

[35] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).
[36] (Emphasis added.)
[37] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> 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 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

[38] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[39] of the Department of Health and Human Services.

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:

> 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]

[40] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[41] *Id.*
[42] *Id.*

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).
>
> (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 *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

[43] *Id.*
[44] (Bold emphasis added.)
[45] 2021 WL 4502052 (D.D.C. 2021).

> 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. § 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:

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

- "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]

- "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, for all or part of the year, 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

[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.* at *11-12.
[59] *Id.* at *12.
[60] *Id.*
[61] Request for EJR at 7.

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 . . . [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

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[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.*
[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.

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.

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 this case 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. 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 this group appeal filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835. The Providers each appealed the issue in the EJR request, and

[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.
[73] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[74] *Id.* at 70555.

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.

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 July 13, 2023, the Medicare Contractor responded to the EJR request, and informed the Board that Federal Specialized Services ("FSS"), on behalf of the Medicare Contractor, will be filing a substantive claim challenge on or before July 27, 2023, in accordance with Board Rule 44.6. Thereafter, on July 20, FSS filed a substantive claim challenge to ***all*** four Providers in this group case, and asserted that appropriate cost report claims for the item under appeal, *i.e.*, Capital Disproportionate Share, were not made by those four Providers.[78] Specifically, FSS contends that none of these Providers claimed reimbursement for the Capital DSH issue in their cost report in accordance with Medicare policy nor did they self-disallow the specific item in the

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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 (July 20, 2023).

cost reports at issue as a protested amount. Further, FSS asserts that none of the exceptions at § 413.24(j)(3)(i)-(iii) applies.[79]

The 4 Providers filed a combined response to the Medicare Contractor's Substantive Claim Challenges on July 27, 2023. The four Providers acknowledged 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 each of the 4 Providers in this appeal. However, each of the 4 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 each of the 4 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 each of the 4 Providers admit that they did not protest the capital DSH issue on their cost reports, they 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 second 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

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[79] *Id.*
[80] Provider's Response to the Substantive Claim Challenge and Second EJR Request at 2 (July 27, 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 1-3, 5-9. The Medicare Contractors did not file a response to the second EJR request, and the time required to do so has now passed. *See* Board Rule 42.4.
[83] Provider's Response and EJR Request at 5-9.

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 this issue in its substantive claim challenge, 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 4 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 this group appeal. 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 year and that the Providers in this group appeal 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 each of the 4 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);

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;

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[84] *Id.* at 11

[85] The Board notes that this question relates to all 4 participants in this case and, as such, does apply to the full group. The Board notes that 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).

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: (a) 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*** (b) 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 for the subject year. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for this issue for the subject year.

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 this group appeal, the Board hereby closes it and removes it 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:

8/9/2023

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Trumbull Memorial Hospital
Provider Number: 36-0055
FYE: 12/31/2014
Case Number: 17-2205

Dear Mr. Ravindran and Ms. Cummings,

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

Pertinent Facts:

Trumbull Memorial Hospital submitted a request for hearing on September 13, 2017, from a Notice of Program Reimbursement ("NPR") dated March 29, 2017. The hearing request included the following issues:

1. DSH SSI (Provider Specific)
2. DSH SSI
3. DSH – Medicaid Eligible Days
4. Uncompensated Care Distribution Pool
5. 2 Midnight Census IPPS Payment Reduction

On May 24, 2018, the Provider filed requests to transfer Issues 2, 4, and 5 to CIRP groups.[1] Issue 2, DSH SSI, was transferred to PRRB Case No. 18-0109GC – QRS CHS 2014 DSH SSI Percentage CIRP Group.[2] On August 1, 2023, the Provider withdrew Issue 3. Issue 1, DSH SSI (Provider Specific), is the sole remaining issue. The Medicare Contractor submitted a

[1] The Provider requested to transfer Issue 2 to Case No. 18-0109GC, Issue 4 to Case No. 18-0113GC, and Issue 5 to Case No. 18-0112GC.
[2] In a letter issued June 13, 2023, the Board closed Case No. 18-0109GC as a duplicate of Case No. 16-1192GC – Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group.

jurisdictional challenge on this issue on July 5, 2018. The Provider did not submit a responsive brief.

In its individual appeal request, the Provider summarizes Issue 1, the DSH SSI (Provider Specific) issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payor 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.[3]

In PRRB Case No. 16-1192GC, Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group, the Providers described the 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

[3] Individual Appeal Request, Issue 1 Issue Statement.

whether the Medicare/SSI Fraction used to calculate the DSH payment accurately and correctly counted the number of patient days to be included therein. The issue statement reads, in part:

> The failure of the Fiscal Intermediary and [CMS] to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes . . .
>
> CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments . . . Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.[4]

On April 25, 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' [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

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

> 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' [sic] 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).

Medicare Contractor's Jurisdictional Challenge

First, the Medicare Contractor contends that Issue 1 is duplicative of the issue in Group Case No. 16-1192GC (Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group). This issue was first transferred to Group Case No. 18-0109GC on May 24, 2018, from this individual appeal, based on the same Medicare Contractor final determination.[5] On June 13, 2023, Group Case No. 18-0109GC was found to be duplicative of Group Case No. 16-1192GC, and the cases were consolidated, with Group Case No. 16-1192GC being the surviving case number.

The Medicare Contractor contends that, "to the extent the Provider is arguing that the SSI percentage is understated and that the Provider needs the underlying data to determine what records were not included, the accuracy portion of this issue is duplicative of the SSI percentage issue in Case No. 16-1192GC."[6] Per PRRB Rule 4.5, a Provider may not appeal the same issue from a final determination in more than one appeal. The Medicare Contractor states: "[a]s the accuracy portion of Issue 1 is also being pursued in Group Case No. 16-1192GC, the [Medicare Contractor] respectfully requests the Board dismiss Issue 1 from the individual appeal consistent with recent jurisdictional decisions."[7]

Second, with respect to the SSI realignment portion of Issue 1, the Medicare Contractor contends that "the appeal regulations do not allow providers to file an appeal to preserve future appeal rights."[8] The regulation at 42 C.F.R. § 412.103(b)(3) "allows a hospital to request that CMS calculate its SSI percentage based on its cost reporting period instead of the Federal fiscal year. Realignment can be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period,

[5] Medicare Contractor's jurisdictional challenge at 1-2 (July 5, 2018).
[6] *Id.* at 3-4.
[7] *Id*.
[8] *Id.*

regardless of if the result is advantageous to the hospital or not. The decision to realign a hospital's SSI percentage with its fiscal year is a hospital election and not a MAC final determination."[9]

The Medicare Contractor argues that "[t]he Provider's appeal is premature, as the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). In addition, the Provide cannot "preserve its right to appeal" a separate issue in a future appeal, and there was no final determination made by the Medicare Contractor for the realignment issue. Therefore, the [Medicare Contractor] requests that the Board dismiss the realignment issue consistent with recent jurisdictional decisions."[10]

Provider's Jurisdictional Response

The Provider did not submit a jurisdictional response.

Board 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 SSI (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*[11] into its appeal.

1. *First and Third Aspects of Issue 1*

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that was 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."[12] The Provider's legal basis for its DSH SSI (Provider Specific) issue asserts that the Medicare Contractor "did not

[9] *Id*.
[10] *Id.* at 5.
[11] 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). !
[12] Issue Statement at 1.

determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 16-1192GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH SSI (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 16-1192GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[15], the Board dismisses this aspect of the DSH SSI (Provider Specific) issue.

In making this finding, the Board notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and, to that end, the Provider is pursuing that issue as part of the group under Case 16-1192GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[16] Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 16-1192GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 16-11926GC, 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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[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 1.3 (July 2015).
[16] 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 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.[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]

[17] Last accessed February 24, 2023.
[18] Emphasis added.

Accordingly, the Board finds that the SSI (Provider Specific) issue in the instant appeal and the group issue from Group Case 16-1192GC are the same 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*.[19]

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH SSI (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 will also be dismissed by the Board.

Board Rule 27 addresses final position papers. Specifically, the content of final position papers is addressed at 27.2:

> The final position paper should address **each issue remaining in the appeal**. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.[20]

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

Board Rule 25.3 Filing Requirements to Board states the following:

> If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issued abandoned and effectively withdrawn.

The Board finds that the Provider abandoned the SSI realignment portion of Issue 1 as it did not brief the issue in its final position paper. As such, the Board dismisses the SSI realignment portion of Issue 1 from the appeal. The Board further notes that realignment of the SSI requires a written request by the Provider. The record contains no evidence of such a request. Therefore, the Medicare Contractor has made no final determination on this issue with which the Provider can be dissatisfied for appeal purposes.

Conclusion:

The Board dismisses Issue 1, the DSH SSI (Provider Specific) issue, in its entirety, from this appeal. As Issue 1 is the sole remaining issue in the appeal, the Board hereby closes Case No. 17-2205 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/9/2023

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

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
Tampa General Hospital (Prov. No. 10-0128)
FYE 9/30/2009
Case No. 23-1498

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal request of Tampa General Hospital ("Tampa" or "Provider") and its request for expedited judicial review ("EJR") filed concurrently on July 11, 2023 to establish the above-referenced individual appeal pertaining to Tampa's fiscal year ("FY") 2009. Set forth below is the decision of the Board to deny Tampa's EJR request and to dismiss Tampa's appeal for lack of jurisdiction.

Issue in Dispute

On July 11, 2023, Tampa filed its appeal request from the final rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule") as it pertains to Tampa's FY 2009 Medicare reimbursement.[1] The same day, Tampa filed a request for EJR.

The ***sole*** issue in this appeal is the proper treatment in the Medicare disproportionate share hospital ("DSH") calculation of days for patients who were enrolled in Medicare Advantage plans under Part C of the Medicare statute ("Part C days") in the aftermath of the *Allina* litigation discussed *infra*. Tampa contends that Part C days must be excluded in their entirety from the SSI fraction and those days must be included in the numerator of the Medicaid fraction (for patients eligible for Medicaid).[2]

Tampa is seeking EJR to challenge in Federal court the policy that the Secretary adopted in the June 2023 Final Rule which is being applied *retroactively* to certain periods prior to October 1, 2013. The Tampa estimates the amount in controversy as $1,230,772 for its FY 2009.

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[5] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] 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.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[13]

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[14] stated that:

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

[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[18]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[19]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[20] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits*

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[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[20] 69 Fed. Reg. at 49099.

> *under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[21]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, the Secretary made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[24]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[25]

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] *Id*. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[25] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).

In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[27] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[28] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[29] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[30] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[31] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[32] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[33] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[34]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[35] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern

[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[28] *Id.* at 2011.
[29] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[30] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[31] 139 S.Ct. 1804 (2019).
[32] *Id.* at 1817.
[33] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[34] 139 S.Ct at 1814.
[35] 85 Fed. Reg. 47723 (Aug. 6, 2020).

> the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[36]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023 (hereinafter the "June 2023 Final Rule").[37] Relevant to the instant EJR Request, the June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[38]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[39]

Finally, in the preamble to the June 2023 Final Rule, the Secretary affirmed that providers which subsequently receive an NPR or revised NPR that reflects the June 2023 Final Rule will have the right to appeal that NPRs/revised NPR:

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[36] CMS Ruling 1739-R at 1-2.
[37] 88 Fed. Reg. 37772 (June 9, 2023).
[38] *Id.* at 37775 (emphasis added).
[39] 88 Fed. Reg. at 37788 (emphasis in original).

> Providers who remain dissatisfied *after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action* retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action.[40]

Tampa's Appeal Request and Request for EJR

A. Proceedings in Prior Appeal under Case No. 23-1438

At the outset, the Board notes that this is the *second* appeal filed by this Provider over this *same* issue involving the *same* fiscal year. On June 9, 2023, the Provider filed an appeal request[41] appealing the June 2023 Final Rule as it pertains to its FY 2009.[42] Within minutes of filing the appeal, the Provider also filed a request for EJR. As discussed in further detail, below, the Board dismissed the initial case *without prejudice* and denied the request for EJR on July 3, 2023.

i. Provider's Appeal Request Establishing Case No. 23-1438

The Provider's appeal request in Case No. 23-1438 included a "Statement of Jurisdiction" asserting that the Provider had met the applicable statutory conditions for appeal because: (1) it "is dissatisfied with the Secretary's retroactive determination . . . in the June 9, 2023, *Federal Register*, to include part C days in the SSI fraction and to exclude those days from the Medicaid fraction of hospitals' DSH payment adjustments under section 1395ww(d)(5)(F) of the statute"; and (2) "the estimated amount in controversy for this appeal exceeds $10,000."[43]

The statement of issue included with the appeal request in Case No. 23-1438 states that the issue concerns the proper treatment in the Medicare DSH calculation of days for Medicare Part C patients in the aftermath of the *Allina* litigation. The Provider contends that the Part C days must be included in the numerator of the Medicaid fraction and excluded from the numerator and denominator of the SSI fraction.

The Provider characterized the relevant background facts as follows:

1. In the FY 2005 IPPS Final Rule, CMS first announced a policy change to count Part C days in the SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

2. In *Allina I*, the D.C. Circuit vacated that policy change.

3. In *Allina II*, the Supreme Court affirmed a D.C. Circuit decision that the Secretary's continued application of the same Part C days policy from the FY 2005 IPPS Final Rule in the 2012 SSI fractions published in 2015 was procedurally invalid because 42 U.S.C.

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[40] 88 Fed. Reg. at 37787 (emphasis added).
[41] Case No. 23-1438.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] Appeal Request, Statement of Jurisdiction (citations omitted).

§ 1395hh(a)(2) required the Secretary to adopt that policy through notice-and-comment rulemaking. The Supreme Court's decision "did not address the D.C. Circuit's alternate ruling that the readopted policy was also invalid under 42 U.S.C. § 1395hh(a)(4) because the Secretary failed to engage in notice-and-comment rulemaking and the policy could not 'take effect' under the terms of the statute until after proper notice-and-comment rulemaking."[44]

4. In the June 2023 Final Rule, CMS adopted the same Part C days policy that had been vacated by *Allina I* and made it retroactive for periods prior to October 1, 2013.

Based on the above, the Provider maintained that the retroactive re-adoption of the Part C days policy in the June 2023 Final Rule "is substantively and procedurally invalid and must be set aside because it was taken without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence."[45]

*ii. Provider's **Prior** Request for EJR*

In Case No. 23-14**3**8, the Provider requested EJR over the "post-*Allina* retroactive Part C policy issue" as it believes it met the requirements for a Board hearing, but the Board lacks the authority to decide the substantive and procedural validity of CMS' Final Rule published in June, 2023.[46]

The Provider asserted that the Board had jurisdiction because:

1. "Here, the Provider is dissatisfied with the Secretary's retroactive determination (for periods prior to October 1, 2013), in the [June 2023 Final Rule] to include part C days in the SSI fraction and to exclude those days from the Medicaid fraction of hospitals' DSH payment adjustments under section 1395ww(d)(5)(F) of the statute."

2. "[T]he Provider filed its appeal within 180 days of publication of the Secretary's final determination in the *Federal Register*, and the impact of this appeal exceeds $10,000."

3. "CMS Ruling 1739-R, providing for remand of certain appeals of the Part C days issue for periods prior to October 1, 2013, does not on its face apply to this appeal because that Ruling 'applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013.'"[47]

In requesting EJR, the Provider sought a determination that the Part C days regulation for periods prior to October 1, 2013 is invalid, and that the Part C days should be included in the Medicaid fraction instead of the Medicare fraction.[48]

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[44] Appeal Request, Statement of Issue (citing to 139 S. Ct. at 1816).
[45] *Id.* (referencing 4 U.S.C. § 706(2)).
[46] Provider's Petition for Expedited Judicial Review, 10 (June 9, 2023).
[47] *Id*. at 11 (quoting Ruling at 2).
[48] *Id.* at 12.

> The Provider contends that the new, post-*Allina* retroactive part C days rule is substantively and procedurally invalid and must be set aside because it was adopted without observance of procedure required by law, and it is otherwise contrary to law, arbitrary and capricious, an abuse of discretion, and unsupported by substantial evidence.[49]

The Provider believed EJR was appropriate because the Board is bound by this regulation,[50] and lacks the authority to provide the relief requested.

*iii. Medicare Contractor's Response to the **Prior** EJR Request*

In Case No. 23-1438, the Medicare Contractor filed an *untimely* response to the EJR Request on June 29, 2023.[51] It argued the Board has no jurisdiction over the appeal because the Provider has not demonstrated the statutorily required dissatisfaction over a final determination. The Medicare Contractor pointed out that 42 U.S.C. § 1395oo(a)(1)(A) requires a provider to be "dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title[,]" but the Final Rule being appealed was not "as to the amount of the payment under subsection (b) or (d) of section 1395ww."[52] It argued that the Final Rule being appealed was similar to the publication of Medicare SSI Ratios in the Federal Register, which may not be final determinations until actually used to calculate a Provider's SSI Ratio.[53] It claimed that the Final Rule appealed in Case No. 23-1438 simply governs the treatment of certain days in the DSH calculation, and until that policy is used to calculate a Provider's DSH payment (*i.e.*, by issuing an NPR), there is no final determination "as to the amount of the payment . . ." to be dissatisfied with, which is required by 42 U.S.C. § 1395oo(a)(1)(A)(i)-(ii).[54]

*iv. Board Decision on the **Prior** EJR Request in Case No. Case No. 23-1438*

On Sunday, July 9, 2023,[55] the Board issued its decision and found that, in Case No. 23-14**3**8, the Provider had not demonstrated that the criteria set out in 42 C.F.R. § 405.1835 had been satisfied "***for the provider's cost reporting period***[.]" The retroactive regulation being challenged was only applicable "***to any cost reports that remain open for cost reporting periods***

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[49] *Id.* at 1.
[50] 42 C.F.R. § 405.1867.
[51] Board Rule 42.4 (Nov. 2021) requires the Medicare Contractor to file a response to an EJR request within five (5) business days of the filing of the EJR Request. A response in this instance would have been due no later than close of business June 16, 2023.
[52] Medicare Contractor's Response to EJR Request at 2.
[53] *Id.* at 3-4 (citing *Memorial Hosp. of South Bend v. Becerra*, 2022 WL 888190 (D.D.C. 2022)).
[54] *Id.*
[55] Due to technical difficulties, this letter was not issued on Friday, July 7, 2023. While the Board issued the letter on Saturday, July 8, 2023, the issuance did not appear in the OH CDMS proceedings tab for Case No. 23-1438. As a result, the Board re-issued it on Sunday, July 8, 2023. Although this letter was issued on Sunday, the Board considers the next business day, Monday, July 10, 2023, to be the date of the Provider's receipt for purposes of determining any relevant filing deadlines.

starting before October 1, 2013."[56] There was nothing in the Provider's request for a hearing which demonstrated that the cost report for the fiscal year at issue in Case No. 23-14**3**8 remained open or had not yet been finally settled and, as such, the [57]Provider had not demonstrated that the June 2023 Final Rule was a "final … determination ***for the provider's cost reporting period***" which involved "*reimbursement* ***due the provider***."[58] Indeed, if the June 2023 Final Rule does not apply to the Provider's fiscal year under appeal in Case No. 23-14**3**8, the actual amount in controversy would be $0. The Board found that there was no evidence to suggest the Medicare Contractor had re-calculated the Provider's FY 2009 DSH adjustment in accordance with the June 2023 Final Rule, nor that it had any intent to do so.

In making this finding, the Board noted that it never reached consideration of the Medicare Contractor's basis for its opposition since there is nothing in the record, *in the first instance*, to establish the requisite nexus between the June 2023 Final Rule and Tampa's FY 2009 Medicare reimbursement. It further noted that "[w]hile the Board is not ruling on the Medicare Contractor's Jurisdictional Challenge and whether its legal theory is applicable *to the case at hand*, . . . it has issued a jurisdictional decision in the context of published SSI percentages and dismissed the relevant case. *See* PRRB Jurisdictional Dec., Case No. 10-0282G (Oct. 29, 2020) (*available at*: https://www.cms.gov/files/document/prrb-jurisdictional-decisions-9-1-2020-through-9-30-2020.pdf)." The referenced jurisdictional decision was appealed to the U.S. District Court for the District of Columbia ("D.C. District Court") as *Memorial Hosp. of South Bend v. Becerra* ("*Memorial Hospital*") and, on March 25, 2022, the D.C. District Court upheld the Board's dismissal.

*B. Provider's Current Appeal and EJR Request in Case No. 23-149**8***

i. Provider's Appeal and EJR Request

*On Tuesday, July 11, 2023**, (just 2 days*** following the Board's July 9, 2023 dismissal of Case No. 23-14**3**8), the Provider established Case No. 23-14**9**8 by filing concurrently *both* a new appeal request based on the June 2023 Final Rule challenging the Secretary's Part C policy stated therein ***and*** a new EJR Request over that Part C issue. Similar to the prior appeal under Case No. 23-1438, the claimed amount in controversy is $1,230,772. Additionally, the calculation support in the instant case is identical to the support submitted with the prior appeal.

In its appeal request, the Provider expanded on its Statement of Jurisdiction. It contends that it is appealing from the ***Secretary's*** "final determination" in the June 2023 Final Rule "to apply retroactively the 2013, rule previously readopted prospectively only, to include part C days as part A entitled days." Pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii) and *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 149 (D.C. Cir. 1986), the Provider insists that it "has a right to appeal this

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[56] 88 Fed. Reg. at 37775 (emphasis added).
[57] No. 20-3461, 2022 WL 888190 (D.D.C. Mar. 25, 2022).
[58] Consistent with the requirement that the determination being appealed must involve "reimbursement due the provider," 42 C.F.R. § 405.1840(b)(2) requires a description of the "payment" at issue and how that payment must be determined differently.

determination" as a determination of the amount of payment under § 1395ww(d) and that it "need not wait until an NPR has been issued" to appeal this "final determination." It also notes that it "has not yet received an NPR for the cost reporting period in this case, and that it is ***not*** appealing the June 2023 Final Rule pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i), but rather appealing it pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(ii), "which provides the right to appeal where a provider is 'dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection . . . (d) of section 1395ww.'"[59]

The Provider argues that appealing the June 2023 Final Rule is appropriate because CMS has announced they will apply this rule to NPRs which have been held open, like its own. It argues that appealing this final rule is no different than appealing from different final rules where the Board has found jurisdiction, such as appeals from Federal Registers announcing CMS' Two-Midnight Rule.[60] It claims appealing the June 2023 Final Rule is not the same as appealing from the publication of SSI fractions the *Memorial Hospital* case, where the Board found it did not have jurisdiction, because the SSI fractions at issue were immediately rescinded and never used, and an accompanying transmittal made clear that CMS was only providing data and that the publication was not a final determination. Here, CMS has made clear that the June 2023 Final Rule is a "final action" which will be used for recalculation of DSH payments for open cost reports, including Provider's own, still-open 2009 cost report.

The Provider's appeal request also expanded on its Statement of Issue compared to the appeal in Case No. 23-1438. In the instant case, the Provider explained that its cost report is still open for the fiscal year at issue:

> As reflected in the agency's records, no NPR has been issued for the cost year ending September 30, 2009, and the records would also reflect that, accordingly, no appeals from an NPR have been filed for that 2009 period.

The Provider characterizes itself as an *Allina* plaintiff, and that its NPR for 2009 has been on hold pending final resolution of the DSH Part C litigation.[61] The following excerpt was added to the current Statement of Issue to expand on this:

> The final rule provides that NPRs will be issued applying the new policy and recalculating DSH payments for Providers like Tampa General whose NPRs have been held open pending resolution of the litigation on the part C days issue. See, e.g., 88 Fed. Reg. at

[59] Statement of Jurisdiction.
[60] In support, the Provider references EJR Decision in Shands Health Care 2014 PPS Rate Reduction Group Appeal, PRRB Case No. 14-1913GC (Feb. 19, 2014) ("*Shands*") which it characterizes as "finding found jurisdiction over appeals challenging rule published in *Federal Register* changing standard to be applied to hospitals to account for the agency's new "two-midnight" policy regarding payment for inpatient hospital services."
[61] Appeal Request, Statement of Issue (citing TDL-13179 (Jan. 30, 2013) (instructing MACs to "hold[] the NPRs for the 29 plaintiff hospitals" in the Allina litigation, including Tampa General); TDL-130516 (Sept. 3, 2013) ("instruct[ing] MACs to continue to hold the NPRs" for these same hospitals)).

> 37,785 ("CMS will issue NPRs and revised NPRs, the DSH adjustments of which will be calculated pursuant to this final action"); id. at 37,788 ("Once this final action is effective, the Secretary will commence issuing NPRs and revised NPRs pursuant to the action, including for those NPRs previously held open"); id. ("CMS's intention was (and is) to issue new and revised NPRs consistent with this final action").

The Request for EJR in the instant case is largely identical to the request in Case No. 23-1438, though two sections were added or updated. First, a Statement of Facts was added which repeats the updates made in the Statement of Jurisdiction.[62] Similarly, the Provider expanded on its analysis of the Board's jurisdiction in its new Request for EJR, repeating the new arguments made in the Statement of Jurisdiction.[63]

ii. Medicare Contractor's Response

On Monday, July 17, 2023, the Medicare Contractor ***timely*** filed its initial response to the EJR requesting a 21-day extension to respond to the EJR request. In asking for the extension, the Medicare Contractor noted that the current appeal and EJR request are similar to the prior but different than prior case (i.e., Case No. 23-14**3**8) and stated an extension was warranted given the speed with which the new appeal and the newness of the issue:

> The MAC had previously objected to that request and laid out its rationale for the objection. Several of the arguments previously raised apply to Provider's present, second, request for EJR but, given the newness of the issue and the speed with which Provider has requested EJR (originally minutes after filing its appeal and now days after the same, potentially defective, appeal was filed) FSS and the MAC require the additional time to unpack Provider's arguments and respond accordingly.

The Medicare Contractor then filed its response 3 days later on Thursday, July 20, 2023.

In its response, the Medicare Contractor concurs with the Provider that there has been no NPR or other final determination issued by the Medicare Contractor for the Provider's FY 2009. It also claims there has been no appealable final determination made by the Secretary regarding the Provider's FY 2009 payment, but that the June 2023 Final Rule "does nothing more than estimate an impact of the 2023 final rule."[64]

The Medicare Contractor once again analogizes to the *Memorial Hospital* case in which the provider challenged the same Part C policy by appealing Medicare SSI ratios published by CMS

[62] Request for EJR, 8-9 (July 11, 2023).
[63] *Id.* at 11-14.
[64] Response to Provider's Request for Expedited Judicial Review, 1-2) (July 20, 2023).

but which the Board found it had no jurisdiction over such an appeal. It notes that, on appeal, the D.C. District Court issued the *Memorial Hospital* decision and upheld the Board's decision, noting the publication of SSI ratios "'was not a determination as to the amount of payment received' based on its observation that '[t]he Medicare-SSI fraction is just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much.'"[65]

The Medicare Contractor continues that "[d]etermining a provider's DSH payment still requires determination of the DPP which, in turn, looks to a myriad of other information such as exhausted benefit days, the number of Part A patients entitled to SSI benefits and the entire Medicaid fraction." It argues that the publication of this DSH policy is not appealable until actually applied to a DSH payment calculation in part because, like SSI ratios, "it is a determination governing the treatment of just one aspect of one of the fractions comprising the DPP."[66]

iii. Provider's Reply to the Medicare Contractor's July 20, 2023 Response

The Provider replied to the Medicare Contractor's July 20, 2023 response and essentially restated its jurisdictional argument. The Provider does note that the Medicare Contractor's July 20, 2023 was not timely filed as a response was due on July 18, 2023 and, as such, the Provider objected to the untimeliness of the Medicare Contractor's filing. In a footnote, the Provider recognizes that, on July 17, 2023, the Medicare Contractor had filed a request for a 21-day extension on the time for it to respond. However, the Provider claimed: (1) 21-day extension request was now moot since the Medicare Contractor filed its response 3 days later on July 20th; and (2) the extension request was not proper because, while the Medicare Contractor was required to file its response to the EJR request in 5 business days and the extension request was timely filed within those 5 business days, the Medicare Contractor failed to confer with the Provider prior to filing that extension request consistent with Board Rule 44.2.

Decision of the Board

Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[67] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[68] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[69]

[65] *Id.* (citing *Memorial Hosp. of South Bend v. Becerra*, 2022 WL 888190, *9 (D.D.C. 2022)).
[66] The Provider filed a Reply to the Medicare Contractor's EJR Response. It notes the Medicare Contractor's response was untimely and largely repeats arguments that were made in previous filings.
[67] 42 C.F.R. § 405.1835(a) (emphasis added).
[68] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[69] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.

- The amount in controversy is $10,000 or more.[70]

42 C.F.R. § 405.1835(b) specifically requires that a provider's request for a hearing must meet the requirements of paragraph (b), subsections (1-4), and paragraph (b)(1) specifically notes that the hearing request must include "[a] demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a)." Paragraph (a) states, in pertinent part, that a provider has a right to a Board hearing:

> with respect to a final … determination ***for the provider's cost reporting period***, if – (1) The provider is dissatisfied with the contractor's final *determination* of total amount *of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803.[71]

42 C.F.R. § 405.1801(a) defines the term "contractor determination" as including:

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

Similarly, Paragraph (b)(2) of 42 C.F.R. § 405.1835 requires certain information relative to each specific item under appeal with respect to the final determination under appeal:

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other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).

[70] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

[71] (Emphasis added.)

> (2) *For each specific item under appeal*, a separate explanation of why, and a description of how, the provider is dissatisfied *with the specific aspects of the final . . . determination under appeal*, including an account of all of the following:
>
> (i) *Why the provider believes Medicare **payment** is incorrect for each disputed item* (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because *it does not have access to underlying information **concerning the calculation of its payment***).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item (as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.

Paragraph (a)(2) also states that a provider must demonstrate that the amount in controversy is $10,000 or more. Satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required before the Board can exercise jurisdiction over an appeal.[72]

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

The Provider emphasize that it is ***not*** appealing the June 2023 Final Rule based on the statutory provision at 42 U.S.C. § 1395oo(a)(1)(A)(i) (which concerns NPR-based appeals). Rather, it is appealing the June 2023 Final Rule based on 42 U.S.C. § 1395oo(a)(1)(A)(ii), which allows an appeal from a Secretary determination as it relates to IPPS reimbursement under 42 U.S.C. § 1395ww(d). The Board notes that this is the same statutory provision relied on by the providers in the *Memorial Hospital* case (which each of the Parties has referenced) when they appealed the publication of SSI ratios.[73] The statutory provision allows an appeal if a provider:

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[72] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain 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*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

[73] 2022 WL 888190.

> (ii) is dissatisfied with a final determination of the Secretary **as to the amount of the payment** under subsection (b) or (d) of section 1395ww of this title

Again, in *Memorial Hospital*, certain providers appealed *the publication* of SSI ratios. While it is true that the D.C. District Court agreed with the Board's rational that the SSI fractions appealed were not a final determination because they were rescinded, the D.C. District Court did not stop there. The D.C. District Court ultimately agreed with the Board that the publication of SSI fractions, even if final, are *not* an appealable "final determination" for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii):

> The difference between the parties boils down to a dispute about whether Plaintiffs have conflated a determination by the Secretary about one of several undetermined elements that eventually flows into the amount of payment and "a final determination of the Secretary as to the amount of the payment." 42 U.S.C. § 1395oo(a)(1)(A) (ii). A challenge to an element of payment under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is only appropriate if, as the D.C. Circuit has explained, "the Secretary ha[s] firmly established 'the only variable factor in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A) (ii).").
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> ****
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> Although Plaintiffs also brought their challenge under § 1395oo(a)(A)(ii), the circumstances that made jurisdiction proper under that subsection are not present here.
>
> In *Washington Hospital Center*, for example, the D.C. Circuit explained that Congress had clearly intended to create two distinct appeals processes—one under 42 U.S.C. § 1395oo(a)(1)(A)(i) for challenges to a MAC's determination of total program reimbursement and one under 42 U.S.C. § 1395oo(a)(1)(A)(ii) to challenge the amount of payment determined by the Secretary under the at-the-time newly introduced Prospective Payment System for Medicare. *See* 795 F.2d at 145. The two processes were not the same because under PPS, "payment amounts are independent of current costs and can be determined with finality prior to the beginning of the cost year[;] ...

> [thus] the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." *Id*. at 146. In other words, because the complete payment amounts could be finally determined before hospitals submitted cost reports, the alternate basis for appeal, 42 U.S.C. § 1395oo(a)(A)(ii), was available.
>
> Similarly, *Sunshine Health Systems* also dealt with whether a challenge was appropriately brought to a final determination of the Secretary or whether additional cost information was required when a hospital challenged a letter finding that it was a new hospital for purposes of the PPS. The Ninth Circuit held that this was a final determination because, as a new hospital, the payments it received under the relevant scheme "would be calculated solely on the basis of the fixed standardized cost averages," and additional information on the hospital's actual costs was not required. *See* 809 F.2d at 1396. Indeed, the "amount of the payment" in § 1395oo(a)(1)(A)(ii) is framed in terms of prospective payments hospitals are to receive—which can be determined with finality in advance of payment — rather than, as here, data as to the number of patient days a hospital actually accrued during a particular period. *See Washington Hosp. Ctr*., 795 F.2d at 147 (amount of payment "is the sum of a [diagnosis-related group] per-patient rate and a target amount per patient" in contrast to "total program reimbursement ... for the period covered by [the cost] report," which is appealed under 42 U.S.C. §§ 1395oo(a)(1) (A)(i)); *St. Francis Hosp. v. Bowen*, 802 F.2d 697, 700–01 (4th Cir. 1986) (amount of payment defined in terms of rates and designed to give prospective information).
>
> ****
>
> There thus remain instances in which a provider can appropriately challenge "a final determination of the Secretary as to the amount of the payment" under § 1395oo(a)(1)(A)(ii) before it has received an NPR. Unfortunately for Plaintiffs, this is not such an instance. The Medicare-SSI fraction is just one of the variables that determines whether hospitals receive a DSH payment and, if so, for how much. The publication of these fractions for FY 2007 was not a determination as to the amount of payment received.[74]

Thus, in its discussion, the D.C. District Court noted that the SSI ratios, *even if they were final*, could not be a "final" determination "as to the amount of payment" because they are just one

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

component of the DSH adjustment.[75] More specifically, challenging the SSI ratios was only a challenge to ***one element*** that eventually flows into the determination of the amount of payment for a final determination. Appealing such an element prior to payment would only be appropriate if it was the ***only*** variable element as to the amount of payment due.[76]

As noted in the excerpt, the providers in *Memorial Hospital* also argued that there are certain instances where a provider can appeal prior to receiving an NPR. The Court distinguished these cases because "the Secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[77] It reiterated that SSI ratios are just one of the variables that determine whether hospitals receive a DSH payment and, if so, for how much.

While the June 2023 Final Rule being appealed in the instant case was clearly promulgated as a final rule, it is ***not*** the only determination or variable on which the Provider's ultimate DSH payment depends.[78] Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating the Provider's DSH payment (*e.g.*, Medicaid eligible days in the numerator of the Medicaid fraction) and, thus, is not an appealable final determination "as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title" (as set forth in 42 U.S.C. § 1395oo(a)(1)(A)(ii)) or as to "the total amount of reimbursement due the provider" (as set forth in 42 C.F.R. § 405.1835(a)).[79]

As discussed above, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Since satisfying the criteria set out in 42 C.F.R. § 405.1835 is required before the Board can exercise jurisdiction over an appeal,[80] and since Tampa has failed to demonstrate in its hearing request that those criteria have been met for the year under appeal (*i.e.*, FY 2009), the Board is permitted under § 405.1835(b) to "dismiss with prejudice the appeal or take any other remedial action it considers appropriate."[81] In this instance, the Board finds it is appropriate to deny the EJR request and dismiss the appeal of the June 2023 Final Rule ***with prejudice*** and remove it from the Board's docket.[82] The Board finds this is an appropriate

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[75] *Id.* at *7.
[76] *Id.* at *8.
[77] *Id.*
[78] It is this fact that distinguishes this case from that in the Board's jurisdictional decision in the *Shands* case referenced by the Provider in *supra* note 60 which ultimately resulted in the D.C. Circuit decision: *Shands Jacksonville Med. Ctr., Inc. v. Azar*, 959 F.3d 1113 (D.C. Cir. 2020).
[79] In this regard, the Board further notes that it is not clear how CMS will implement the June 2023 Final Rule including, for example, whether new SSI ratios will be published for providers for the federal fiscal years at issue in this appeal as a result of the issuance of the June 2023 Final Rule based on a re-running of the data matching process.
[80] 42 C.F.R. § 405.1840(a), (b).
[81] 42 C.F.R. § 405.1835(b).
[82] The Board's dismissal does not prevent the Provider from appealing this same issue *from the **NPR*** pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i) once it is issued which per the June 2023 Final Rule should be issued soon (assuming there are no other pending/unresolved issues from the cost report audit process). In this regard, the Board notes that the June 2023 Final Rule affirmed that a provider in this situation may appeal the NPR for the Part C issue. *See supra* note 40 and accompanying text. The Board also notes that the Provider could have appealed the Part C issue from the non-issuance of an NPR as delineated at 42 U.S.C. § 1395oo(a)(1)(B) and implemented at 42 C.F.R. § 405.1835(c), but apparently chose not to do so within the time frame specified in 42 C.F.R. § 405.1835(c).

remedial action based on its findings that the June 2023 Final Rule ***itself*** is *not* an appealable final determination under 42 U.S.C. § 1395oo(a)(1)(A)(ii).[83]

Finally, the Board recognizes that the Medicare Contractor requested a 21-day extension on the time to respond to the EJR request and that this response was filed 3 days later but before the Board could rule on that request. The Board hereby accepts the Medicare Contractor's July 20th filing as timely and, in accepting it, notes that it had already previously recognized the Medicare Contractor's concerns and validates the basis for the Medicare Contractor's extension request. That said, *the Board reminds the Medicare Contractor of its obligation under Board Rule 44.2 to attempt to confer with the Provider* ***prior to*** *filing an extension request*, even when (as here) the time constrains are short and, as part of the extension request, to either "summarize the efforts it made to contact the opposing party to discuss the merits of the motion and whether the opposing party will concur or oppose the motion" or "[i]f the moving party has attempted to confer but has been unsuccessful, briefly describe the attempts made." Here, it is unclear whether the Medicare Contractor unsuccessfully attempted to contact the Provider prior to filing the extension request. Given the totality of the circumstances surrounding this case (including but not limited to the speediness of this appeal and EJR request and narrow window in which to file its response), the Board declines to not accept the Medicare Contractor's response to the EJR request and, as such, it is part of the record for this case.

In summary, the Board denies the EJR request and dismisses this appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/9/2023

X Clayton J. Nix

Clayton J. Nix, Esq
Chair
Signed by: PIV

CC: Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[83] Again, this does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted in the preamble to the June 2023 Final Rule (*see supra* note 40 and accompanying text), providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy. This obviously would encompass the Provider yet-to-be-issued NPR for the fiscal year at issue. *See supra* not 82.

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Fannin Regional Hospital (Prov. No. 11-0189)
FYE 12/31/2015
Case No. 19-0080

Dear Mr. Wilson and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0080 in response to two jurisdictional challenges filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 19-0080*

Fannin Regional Hospital ("Provider") appealed an original Notice of Program Reimbursement (NPR) dated March 14, 2016 for its fiscal year end (FYE) December 31, 2015 cost reporting period. On October 5, 2018, the Provider filed an individual appeal request which contained the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific),
- Issue 2: DSH/SSI Percentage,[1]
- Issue 3: DSH Medicaid Eligible Days,
- Issue 4: Uncompensated Care Distribution Pool,[2] and
- Issue 5: 2 Midnight Census IPPS Payment Reduction.[3]

As the Provider is commonly owned by QHCCS, LLC, the Provider transferred Issues 2, 4, and 5 to common issue related party ("CIRP") groups for Quorum Health. On November 23, 2018, the Provider filed a Model Form C – Request to Add Issue regarding the Standardized Payment

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

Amount, Issue 6. Then on May 28, 2019, the Provider withdrew Issue No. 6 addressing the Standardized Payment Amount in the cover letter for its Preliminary Position Paper.

Issue 1 (DSH/SSI Provider Specific) and Issue 3 (DSH Medicaid Eligible Days) are the only remaining issues in this appeal.

The MAC filed a Jurisdictional Challenge on January 31, 2019, regarding Issue 1 (DSH SSI Provider Specific).[4] On March 2, 2023, the MAC filed a second jurisdictional challenge regarding Issue 3: Medicaid Eligible Days.

Significantly, the Provider did not respond to the MAC's jurisdictional challenges. Pursuant to Board Rule 44.4.3, "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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

In their Individual Appeal Request, Provider summarizes Issue 1, the DSH/SSI – Provider Specific issue, as follows:

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

The Provider contends that its SSI percentage published by ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[6] The amount in controversy was listed as $6,000.[7]

As noted above, the Provider transfer Issue 2, the systemic SSI percentage issue, to the CIRP group under Case No. 18-1333GC. The Provider described Issue 2 in its appeal request as follows:

> The Provider contends that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi)(I). The

[4] The MAC also challenged Issue 4 (Uncompensated Care Distribution Pool), Issue 5 (2 Midnight Census IPPS Payment Reduction), and 6 (Standardized Payment Amount), however, these issues no longer reside in this appeal.
[5] Individual Appeal Request, Tab 3 – Appealed Issues, Issue 1. (Oct. 1, 2018).
[6] *Id.*
[7] *Id.*

> Provider contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as 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 indivudals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondayr Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculatd by [CMS] fail to address all of the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible days, and
> 6. Covered days vs. Total days[8]

The group issue statement for Case No. 18-1333GC challenges the new post-*Baystate* data matching process and lists the same 6 non-*Baystate* issues with a detailed explanation of the "Covered days versus Total days" issue. The Provider lists the amount in controversy for Issue 2 (including after transfer to Case No. 18-1333GC) as $6,000 which is the same amount in controversy as Issue #1 in the individual appeal.

On May 28, 2019, the Provider filed its preliminary position paper. The following is the Provider's *complete* position on Issue 1 set forth therein:

[8] *Id*. at 2.

> Calculation of the SSI Percentage
>
> Provider Specific
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's fiscal year end (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).[9]

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 $6,184.

MAC's Contentions

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

In the MAC's jurisdictional challenge filed on January 31, 2019, the MAC contends that that the aspect of Issue 1 - DSH SSI Percentage (Provider Specific) which concerns SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment should be dismissed because it is duplicative of Issue 2. The MAC adds that the aspect of Issue 1 which addresses DSH SSI realignment is not an appealable issue as there has not been a final determination regarding this issue as required by 42 C.F.R. § 405.1835, and the Provider decision to change the

[9] Provider's Preliminary Position Paper at 8-9 (May 15, 2019).

DSH Medicare computation fiscal year end ("realignment") is a Provider election. The Provider is required to make a realignment request in writing to the intermediary and CMS, and this is not a cost item claimed on the cost report. The MAC asserts the Provider can request a reopening of its cost report to apply a realigned SSI percentage but cannot appeal this issue to the PRRB.

Issue No. 2 – DSH Medicaid Eligible Days

In the MAC's jurisdictional challenge filed on March 2, 2023, the MAC claims that the Provider has abandoned the DSH Medicaid Eligible Days issue in this appeal. The MAC asserts the Provider has failed to properly develop argument pertaining to this issue in the preliminary position paper in accordance with Board Rule 25.[10] The MAC adds that the Provider has failed to provide a list of additional Medicaid eligible days or any other supporting documents regarding this issue and has failed to explain why it cannot produce these documents. The MAC indicates it requested the required documentation from the Provider regarding the DSH Medicaid Eligible Days issue on three separate dates – November 20, 2018, February 4, 2019, and January 18, 2023, and has failed to receive the documentation.[11]

Provider's Response

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

Board Analysis and Decision

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

A. DSH SSI Percentage (Provider Specific)

The analysis for Issue 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.

[10] Medicare Contractor's Jurisdictional Challenge (March 2, 2023) at 1 - 4.
[11] Medicare Contractor's Jurisdictional Challenge (Mar. 2, 2023) at 4-7. *See also* Jurisdictional Challenge Ex. C-1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1involves the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. This issue concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[12] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "the SSI percentage published by CMS [the Centers for Medicare and Medicaid Services] was incorrectly computed . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[15] 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.[16]

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 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,[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 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.[18] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal.

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[12] Individual Appeal Request, Tab 3 – Appealed Issues, Issue 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rule 7 (Aug. 29, 2018).
[16] PRRB Rules 8.1 and 8.2 (Aug. 29, 2018).
[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).

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. 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.[19]

Board Rule 25 states the requirements for preliminary position papers:

> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers *must* include the elements addressed in the following subsections.
>
> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, *state the material facts that support the provider's claim.*
>
> C. *Identify the controlling authority*, (e.g. statutes, regulations, policy or, case law) *supporting the provider's position*.
>
> D. *Provide a conclusion applying the material facts to the controlling authorities*.
>
> 25.2 Position Paper Exhibits

[19] (Italics emphasis added)

> 25.2.2 Unavailable and Omitted Documents
>
> *If documents necessary to support your position are still unavailable*, identify the missing documents, *explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

> (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.

Finally, as explained in the Commentary to Board Rule 23.3, the Board requires position papers "to be *fully* developed and include *all available* documentation necessary to give the parties a thorough understanding of their opponent's position." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged provider-specific "errors" in its Preliminary Position Paper and include *all* exhibits. In particular, the Preliminary Position Paper 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

[20] (Italics emphasis added)

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

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. 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.[22]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.**[23] This CMS webpage describes access to DSH data *from 1998 to 2017* as follows: "DSH is now a self-service application. This *new self-service process* enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[24]

The Provider in this appeal offers no material facts or evidence pertaining to its FYE 12/31/2015 DSH SSI Percentage data errors, either in its appeal request or in its preliminary position paper.

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[21] There are no exhibit or citations to state records or examples of how SSI entitlement can be ascertained from state records.
[22] 70 Fed. Reg. 47277, 47439 (Aug. 12, 2005).
[23] Last accessed March 14, 2023.
[24] (Emphasis added.)

It is also noted, that the Provider did not file a final position paper in this appeal (as the appeal was filed after August 29th, 2018, the final position paper was optional).

Accordingly, based on the record before it,[25] the Board finds that Issue 1 in the instant appeal and the group issue from Group Case 18-1333GC are the same issue. Moreover, the Provider has failed to properly develop the merits of Issue 1 in compliance with Board Rule 25.2.2 and 42 C.F.R. 405.1853(b)(2) because the Provider's preliminary position paper (the only briefing filed by the Provider in this appeal) did not set forth the relevant facts and arguments regarding the merits of this Provider's claims with regards to the DSH SSI Percentage data errors aspect of Issue 1. The Board finds that the Provider has abandoned the DSH SSI Percentage data errors issue by filing a perfunctory position paper that did not include any discussion or analysis of the MedPAR data files that are available to providers. Based on these multiple and independent bases, the Board hereby dismisses this aspect of Issue 1 from the appeal.

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

B. Medicaid Eligible Days

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

> 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 C.F.R. § 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

[25] 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.

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 7, 9, 25, S-D. *See* Tab 4.
> Estimated Reimbursement Amount: $28,000. *See* Tab 5.[26]

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

On May 28, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[27] As of the filing of the second jurisdictional challenge on March 2, 2023, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days, though their Calculation Support filed with the position paper notes a net impact of $28,457, with an increase in days. To date, the Provider has not responded to the challenge alleging the listing was submitted as required, nor has the Board been notified by either party that the listing was eventually submitted. The Provider also did not file an optional final position paper by the Board set deadline.

Specifically, the Provider's complete briefing of this issue in its preliminary position paper (the only briefing in the appeal) is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[26] Individual Appeal Request, Issue 3.
[27] Provider's Preliminary Position Paper (Apr. 26, 2017) at Exhibit 1.

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[28]

In its jurisdictional challenge, the MAC asserts that the Provider has been given ample opportunity to submit a list of additional Medicaid eligible days and has failed to do so. While the Calculation Support filed with their appeal notes a net impact of $28,457, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.2. (Aug. 2018) states:

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

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover, notwithstanding multiple requests from the MAC. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[29]

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

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

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[30]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

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

Similarly, with regard to position papers,[31] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[32] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[33]

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[34] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days in dispute and the actual amount in controversy is $0 for this issue.

[34] (Emphasis added).

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[35]

****

In summary, the Board hereby dismisses the DSH SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of Issue 2 that was transferred to Case No. 18-3333GC and because the Provider has failed to comply with Board Rule 25.2.2 and 42 C.F.R. § 405.1853(b)(2)-(3) by setting forth in its preliminary position paper the relevant facts and arguments regarding the merits of this Provider's claims (including exhibits) with regards to the DSH SSI Percentage alleged errors that were allegedly "provider specific." Additionally, there no final determination from which the Provider can appeal the DSH SSI Percentage 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 pursuant to 2 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25. In making these dismissals the Board takes administrative notice that it has mad similar dismissals of both SSI provider specific and Medicaid eligible days issues involving other Quorum providers for the same reasons.[36] As no issues remain pending, the Board hereby closes Case No. 19-0080 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:

8/11/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[35] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[36] Examples of Quorum individual provider cases which the Board dismissed the SSI Provider Specific issue for being a prohibited duplicate and the Medicaid eligible days issue for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 17-2247 (dismissed by Board letter dated Aug. 26, 2022 prompted by MAC filings dated Apr. 10, 2018 & June 16, 2022); Case No. 19-2771 (dismissed by Board letter dated May 1, 2023 prompted by MAC filings dated Jul. 2, 2020, Jan. 11, 2023, & Feb. 28, 2023); Case No. 19-0084 (dismissed by Board letter dated June 16, 2023 prompted by MAC filings dated Feb. 8, 2019, Dec. 30, 2022, & Feb. 14, 2023). Similarly, FY 2013, the Board dismissed the ***same*** Provider's appeal of Medicaid eligible days in Case No. 16-1828 by letter dated May 22, 2023 for the same reason prompted by a MAC filing dated March 2, 2023.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Reynolds Memorial Hospital (Prov. No. 51-0013)
FYE 12/31/2017
Case No. 22-0711

Dear Mr. Ravindran and Ms. Johnson:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 22-0711, pursuant to a jurisdictional challenge filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 22-0711

On February 8, 2022, Reynolds Memorial Hospital's ("Reynolds" or "Provider"), appealed a Notice of Program Reimbursement ("NPR") dated August 20, 2021, for its fiscal year end ("FYE") December 31, 2017 cost reporting period. The Provider appealed the following issues:[1]

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

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 West Virginia University Health System ("WVU Health"). Accordingly, the Provider transferred issues to various CIRP group appeals, including Issue 2, DSH/SSI Percentage (Systemic Issues) to Case No. 22-1450GC entitled "WVU Medicine CY 2017 DSH SSI Percentage CIRP Group." After all transfers, two

[1] Provider's Request for Hearing at Issue Statement (Feb. 8, 2022).

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

On October 1, 2022, the Provider filed its Preliminary Position Paper.

On January 11, 2023, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1, addressing the DSH SSI Percentage (Provider Specific) issue and Issue 3, DSH Medicaid Eligible Days. Significantly, the Provider did not file a response to the Jurisdictional Challenge in compliance with 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.[3]

On January 25, 2023, the Medicare Contractor filed its preliminary position paper.

B. ***Description of Issue 1 in the Appeal Request***

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

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

[2] MAC's Jurisdictional Challenge, at 2 (Jan. 11, 2023).
[3] (Emphasis added.)

> CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

As discussed above, the Provider transferred Issue 2 to the CIRP group under Case No. 22-1450GC entitled "WVU Medicine CY 2017 DSH SSI Percentage CIRP Group." The CIRP group has the following issue statement:

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

The amount in controversy listed for the Provider as a participant in 22-1450GC is $8,505.

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

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all

[4] Provider's Request for Hearing, Issue Statement (Feb. 8, 2022).

> patients that were entitled to SSI benefits in their calculations 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. S*ee* 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 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $8,505. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 22-1450GC.

MAC's Contentions:

Issue 1 – DSH SSI Percentage (Provider Specific)

The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 22-1450GC, *WVU Medicine CY 2017 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[6]

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

[5] Provider's Preliminary Position Paper, at 8-9 (Oct. 1, 2022)
[6] MAC's Jurisdictional Challenge, at 2.

Issue 3 – DSH Medicaid Eligible Days

The MAC also argues that the Provider has abandoned the DSH – Medicaid Eligible Days issue. Pursuant to Board Rule 25.3, parties should file a complete preliminary position paper with a fully developed narrative, all exhibits, a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853, which the Provider did not do with respect to the Medicaid eligible days issue.[7]

Provider's Response:

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

Board Analysis and Decision:

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

A. SSI Provider Specific

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue directly filed into Case No 22-1450GC, *WVU Medicine CY 2017 DSH SSI Percentage CIRP Group.*

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. 22-1450GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH]

[7] *Id.*

Calculation."[8] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[10] The DSH systemic issues filed into Case No. 22-1450GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $8,505.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 22-1450GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 22-1450GC (which the Provider is obligated to do since it is a common issue subject to 42 C.F.R. § 405.1835(b)(1)). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[11] 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) in its appeal request of 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. 22-1450GC.

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. 22-1450GC, 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

[8] Individual Appeal Request, Issue 1.
[9] *Id.*
[10] *Id.*
[11] 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).

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

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

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

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

[12] There are no exhibits or citations or examples of how SSI entitlement can be ascertained from state records.

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[13] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[14]

Accordingly, based on the record before it,[15] the Board must find that Issues 1 and the group issue in Group 22-1450GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules governing position papers.

2. Second Aspect of Issue 1

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

B. DSH Medicaid Eligible Days

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

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

[13] (Last accessed Nov. 21, 2022.)
[14] (Emphasis added.)
[15] Again, the Provider failed to respond to the jurisdictional challenge and the Board must make its ruling based on the record before it.

> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees [*sic*] with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[16]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

On October 1, 2022, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case (e.g., whether there remained the same number of days as suggested in the appeal request or more or less). Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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

[16] Provider's Request for Hearing, Issue Statement (Feb. 8, 2022).
[17] Provider's Preliminary Position Paper, at 10 (Oct. 1, 2022)

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2017 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

While the Calculation Support filed with their appeal notes a net "estimated impact" of $24,592, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper because the Provider's preliminary position paper fails to identify what, if any, Medicaid eligible days are in actual dispute. Rather, the preliminary position paper attached the same "estimated impact" as confirmed by the fact that the actual listing was promised to be send under separate cover.[18] However, that listing has not been forthcoming and has not ever been made part of the record before the Board

Board Rule 7.3.1.2 (Nov. 2021) states:

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

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

[18] (Emphasis added.)

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[19]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[20]

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

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

Similarly, with regard to position papers,[21] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[22] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

---

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

[20] (Emphasis added.)

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

[22] (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.[23]

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

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

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

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the 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

[23] (Emphasis added.)

it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed" [24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. As such, based on the record before it, the Board must find that there are no actual days at issue and the actual amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute 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.[25]

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 22-1450GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. The Board also dismisses Issue 3, DSH Medicaid Eligible days, as in violation of the Board Rules and regulations.

In so finding, the Board takes administrative notice that it has made similar dismissals in *numerous* other cases in which QRS was the designated representative.[26] Notwithstanding, QRS failed to

[24] (Emphasis added.)
[25] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.
[26] Examples of QRS-represented individual provider cases which the Board dismissed the SSI Provider-Specific issue and/or the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (Medicaid eligible days issue]dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16-2521 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (Medicaid eligible days only dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (Medicaid eligible days dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (both issues dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 17, 2018 and Mar. 2, 2022); Case No. 17-1747 (both issues dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filings dated May 24, 2018 and Oct. 17, 2022); Case No. 15-2294 (Medicaid eligible days issue dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (both issues dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (both issues dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (both issues dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Mar. 8, 2023).

properly distinguish/develop the SSI Provider Specific issue in its appeal request or its preliminary position paper and failed to provide the Medicaid eligible days listing with its preliminary position paper. Indeed, notwithstanding these other dismissals and underlying MAC filings, QRS failed to respond to the January 11, 2023 jurisdictional challenge raised by the MAC in this case.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/14/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Isaac Blumberg
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RE: ***Request for Rescission of Remand and Bifurcation of Group Appeal***
Providence Health System 2000 – 9/30/2004 Dual Eligible Days Group
Case No. 09-0748GC

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-referenced appeal in response to the Request for Rescission of Remand and Bifurcation of Individual Appeal Regarding DSH Part C Days issue. The Board hereby **denies** the request for rescission of the remand and bifurcation of the dual eligible Part A non-covered and Part C days issues. The decision of the Board is set forth below.

Background

In Case No. 09-0748GC, the Providers described the Dual Eligible days issue, which includes the same fiscal year end as in the instant appeal, as:

> Dual Eligible Days are patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the MEDPAR system **via Fee For Service Medicare Part-A**. Moreover, **these** days were disallowed from the Medicaid numerator as well. Hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with the undisputed indigent population. As the days represent patient who were Medicaid Eligible but not Medicare Entitled, the Provider contends that **these** days should be included in the Medicaid fraction.
>
> Dual Eligible Days were excluded from the Medicaid fraction for a variety of reasons. By way of example, certain Dual Eligible Days are days associated with patients who are eligible for Medicaid but have exhausted their Medicare Part A benefits ("Exhausted Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held

> The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. *See Jersey Shore Medical Center v. Blue Cross and Blue Shield of New Jersey*, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, *vacated and remanded*, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("*Jersey*").
>
> Thus, in accordance with the Board's holding in the Edgewater, the Provider's Medicaid fraction should include all "Exhausted Days".

On May 13, 2013, the Board, on its own motion, bifurcated the period from 10/1/2004 – 12/31/2004 and established a new group appeal for that period (Case No. 09-0937GC), which was *not* subject to 1498-R Remand. The period prior to 10/1/2004 remained in the appeal. The Board concluded this letter:

> Finally, as noted earlier in this letter, ***the issue in dispute*** in case number 09-0748GC ***is subject to the provisions of CMS Ruling 1498-R***. Therefore, the Board is requiring Blumberg Ribner, Inc. submit a final Schedule of Providers and the associated jurisdictional documentation for case number 09-0748GC to the Board within 60 days of the date of this letter.

On July 11, 2013, Blumberg Ribner submitted the final Schedule of Providers ("SOP"). Significantly, in the filing the SOP, Blumberg Ribner did *not* object to the planned 1498-R remand, *nor* did it notify the Board that there were any other issues in the case.

On August 7, 2013, the Board reviewed the SOP and, consistent with its May 13, 2013 notice, remanded the Providers in Case No. 09-0748GC to the Medicare Contractor pursuant to CMS Ruling 1498-R[1] and closed the appeal.

Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue

On June 3, 2016, the Board received a letter from Blumberg Ribner ***on behalf of one Provider*** in the group – Saint Joseph Medical Center FYE 2000 – requesting rescission of the remand and

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

bifurcation of the Part C issue. The Providers argues that the references to dual eligible patient days were intended to refer to persons eligible for Part A and Part C.[2]

Blumberg Ribner argues that:

> The Board should find that it possessed authority over the dual eligible days issue. The Board's finding that it lacked jurisdiction over, and the [1498-R] remand of, the dual eligible days issue was inappropriate because it was the intent of the Providers to appeal the Medicare Part C days issue.

Blumberg Ribner refers to a decision in Case No. 08-2624GC in which the Board granted bifurcation of dual eligible Part A and Part C days in Sutter Health 1998 DSH Dual Eligible Days CIRP Group. In that December 30, 2015 letter, the Board stated:

> [T]he Board acknowledges that *at the time that Sutter Health's individual and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or HMO/Part C days.* Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the *providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both dual eligible Part A non-covered days and HMO days.* (Emphasis in original).[3]

Blumberg Ribner next argues that the Board has the authority to reopen its remand decision and should do so. They reference 42 C.F.R. § 405.1885(b)(3), "A Secretary or contractor determination or decision by the reviewing entity may be reopened and revised at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision." They conclude that that the MAC was at fault in accepting the dual eligible days remand, and the Board should reopen the remand decision.

Last, Blumberg Ribner argues that their appeals were filed in accordance with Board Instructions in effect at the time the Providers filed their appeals. The Instructions stated:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law . . . **You must precisely identify the component of the DSH issue that is in dispute.**

---

[2] Bifurcation Request Letter at 1 (May 27, 2016).
[3] *Id.* at 2.

Blumberg Ribner argues that these Instructions did not require that they state the issue as "finely" as would be required under later rules. The Providers conclude that they were required to precisely define the DSH component at issue, which they did.

Board's Analysis and Decision

Board Rule 46.1 (July 1, 2015), in effect at the time the request was filed, addresses how the Board handles a Motion for Reinstatement: , provides "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case . . . if an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the Provider must address whether the CMS ruling permits reinstatement of such issue(s)/case."

> **46.1 – Motion for Reinstatement**
> A Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the Provider's withdrawal of the issue(s) (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will *not* reinstate an issue(s)/case *if the Provider was at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the Provider *must* address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the Provider will have the same rights (no greater and no less) that it had in its initial appeal. These requirements also apply to Rules 46.2 and 46.3 below.[4]

As an initial matter, the Board finds that the request for rescission of the remand and bifurcation of the issues is *fatally* flawed because the request was only filed for ***one*** of the Providers in the group rather than the entire group. As such, the request implicitly is asking for reinstatement of Case No. 09-0748GC to allow bifurcation of one provider for one issue. However, Case No. 09-0748GC is a common issue related party ("CIRP") group formed pursuant to 42 C.F.R. § 405.1837(b) and, therefore, the issue(s) in the appeal must be common to ***all*** of the providers, not just one. This fatal flaw in the reinstatement request alone is a sufficient basis to deny the reinstatement/reopening request.

Additionally, as discussed above, on May 13, 2013, the Board specifically notified the Providers that it had bifurcated the period from 10/1/2004 – 12/31/2004 and established a new group appeal for that period (09-0937GC) because it was not subject to 1498-R Remand. The Board then specifically notified Blumberg Ribner that the Board intended to remand Case No. 09-0748GC the period prior to 10/1/2004 since it was subject to 1498-R remand and requested that Blumberg Ribner submit an SOP so that it could then carry out that remand. Accordingly,

[4] (Emphasis added.)

following Blumberg Ribner's filing of the requested SOP for Case No. 09-0748GC, the Board reviewed the SOP, remanded Case No. 09-0748GC, and then closed that case. Neither the Providers nor the group representative objected to the planned remand nor raised any issue to the Board that the appeal should not be bifurcated between those fiscal periods because the Part C days issue was also pending in the appeal. Had the Providers intended to pursue the Part C days issue, they should have notified the Board at that time, if not sooner. Accordingly, an independent basis to deny reinstatement/reopening request is that, to the extent the alleged Part C issue was ever part of Case No. 09-0748GC, the Providers abandoned it by failing to properly notify the Board the alleged Part C days issue when the Board notified the Providers of the pre- and post-10/1/2004 bifurcation ***and*** the Board's intention to remand the pre-10/1/2004 period following receipt of the SOP for that period. Accordingly, it is clear that the Providers have not established good cause to reinstate/reopen Case No. 09-0748GC.

Last, the Board notes that the issue statement of the group appeal defines the days at issue in group dual eligible days issue as "Fee For Service Medicare Part-A" days which is clearly the dual eligible days Part A issue, and does *not* contemplate alleged Medicare+Choice Managed Care/Part C days issue since "Fee For Service Medicare Part-A" does not encompass Part C. Accordingly, a third and independent basis upon which to deny reinstatement/reopening is that the alleged Part C Days issue was never part of the group appeal issue statement and, as such, it is clear that the proposed reinstatement for purposes of bifurcation has no merit.

As pointed out in the rescission and bifurcation request, regulations and Board rules require specificity with regards to each item under appeal. 42 C.F.R. § 405.1835(b)(2) (2009) reads, in part:

> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of the following:
>
> (i) Why the provider believes Medicare payment is incorrect *for each disputed item* . . .[5]
>
> (ii) How and why the provider believes Medicare payment must be determined differently *for each disputed item.*[6]

Board Rules have also long required that providers include identification of the issues in dispute with specificity:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending the findings and conclusions are incorrect . . . You

[5] Emphasis added.
[6] 42 C.F.R § 405.1835(b)(1)-(2). (Emphasis added.)

> must clearly and specifically identify your position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not definite the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[7]

The Board finds that the issue statement for the group appeal can only be read to encompass the dual eligible Part A days issue. The group appeal issue language does not meet the specificity requirements as set forth in the regulation and Board rules to have appealed the dual eligible Part C days issue.

This finding is consistent with the recent ruling by the U.S. District Court for the District of Columbia in *Evangelical Community Hospital, et al. v. Becerra*.[8] In that case, the provider's issue was tied to improper calculation to DSH payment and read in part, "[t]he intermediary erred by incorrectly calculating the SSI percentage for inclusion in the 'Medicare Fraction' for purposes of the calculation of the provider's [disproportionate share] payment . . ."[9] The Court found that "[t]his description does not specify which portion of the calculation was incorrect nor how the fraction should have been calculated differently."[10] The Court found that this was a description of the issue was a violation of Board rules and a proper basis on which for the Board to dismiss the appeal.[11] Here, the Board makes the same finding based on similarly overly generalized language.

For the reasons set forth above, the Board **declines** to exercise its discretion to reopen and reinstate Case No. 09-0748GC and, thus, **denies** the request for reinstatement and rescission of remand in order to bifurcate a single participant from the group appeal regarding the Part C Days issue. Accordingly, Case No. 09-0748GC remains closed.

Board Members Participating:

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

For the Board:

8/14/2023

X Clayton J. Nix

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

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

[7] Provider Reimbursement Review Board, Part I, B, II. (March 1, 2002).
[8] 21-cv-01368 (APM) (D.D.C. Sep. 30, 2022).
[9] *Id*. at 11.
[10] *Id*.
[11] *Id*.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision – SSI Percentage (Provider Specific), Medicaid Eligible Days, & UCC Payment Distribution Pool***
Galesburg Cottage Hospital (Prov. No. 14-0040)
FYE 04/30/2016
Case No. 19-0958

Dear Mr. Wilson and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 19-0958 in response to two jurisdictional challenges filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 19-0958*

Galesburg Cottage Hospital ("Provider") appealed an original Notice of Program Reimbursement ("NPR") dated July 3, 2018 for its fiscal year end ("FYE") April 30, 2016 cost reporting period. On January 3, 2019, the Provider filed an individual appeal request which contained the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific),
- Issue 2: DSH/SSI Percentage,[1]
- Issue 3: DSH Medicaid Eligible Days,
- Issue 4: Uncompensated Care Distribution Pool,
- Issue 5: 2 Midnight Census IPPS Payment Reduction,[2] and
- Issue 6: Standardized Payment Amount.[3]

As the Provider is commonly owned by QHCCS, LLC, the Provider transferred Issue 2 and 5 to common issue related party ("CIRP") groups for Quorum Health. On August 20, 2019, the Provider withdrew Issue 6 addressing the Standardized Payment Amount in the cover letter for its Preliminary Position Paper. As a result of these transfers and withdrawal, the remaining

[1] On July 22, 2019, this issue was transferred to the CIRP group under Case Number 19-1503GC.
[2] On July 22, 2019, this issue was transferred to the CIRP group under Case Number 19-1504GC.
[3] Individual Appeal Request, Tab 3 - Appeal Issues.

issues in this appeal are Issue 1 (DSH/SSI Provider Specific), Issue 3 (DSH Medicaid Eligible Days) and Issue 4 (Uncompensated Care Distribution Pool).

On April 5, 2019, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1 (DSH SSI Provider Specific) and Issue 4 (Uncompensated Care Distribution Pool).[4] On March 2, 2023, the Medicare Contractor filed a second Jurisdictional Challenge regarding Issue 3, Medicaid Eligible Days.

Significantly, the Provider did not respond to the MAC's Jurisdictional Challenges. Pursuant to Board Rule 44.4.3: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1503GC

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

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

The Provider contends that its SSI percentage published by ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.[6] The amount in controversy was listed as $14,000.[7]

In the SSI percentage issue in CIRP group under Case No. 19-1503GC, which includes the Provider in this case, and the same fiscal year, the Providers assert that:

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

---

[4] The MAC also challenged Issue 5 (2 Midnight Census IPPS Payment Reduction) and Issue 6 (Standardized Payment Amount). However, Issue 5 no longer resides in this appeal and Issue 6 was withdrawn.
[5] Individual Appeal Request, Tab 3 – Appealed Issues, Issue 1. (Jan. 2, 2019).
[6] *Id.*
[7] *Id.*

> 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.[8]

The amount in controversy for Provider No. 14-0040 in Case No. 19-1503GC is $14,000, the same amount as issue #1 in the individual appeal.

On August 20, 2019, the Provider filed its preliminary position paper. The following is the Provider's *complete* position on Issue 1 set forth therein:

> Calculation of the SSI Percentage
>
> Provider Specific
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's fiscal year end (April 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. 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

[8] *Id*.

> determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[9]

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 $14,118.

MAC's Contentions

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

In the MAC's jurisdictional challenge dated April 5, 2019, the MAC contends the aspect of Issue 1 - DSH SSI Percentage (Provider Specific) which concerns SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment should be dismissed because it is duplicative of Issue 2. The MAC adds that the aspect of Issue 1 which addresses DSH SSI realignment is not an appealable issue as there has not been a final determination regarding this issue as required by 42 C.F.R. § 405.1835, and the Provider decision to change the DSH Medicare computation fiscal year end ("realignment") is a Provider election. The Provider is required to make a realignment request in writing to the intermediary and CMS in order to receive a realigned SSI percentage. The MAC's position is that appeal of realignment is premature as there has not been a formal request for SSI realignment in accordance with 42 C.F.R. § 412.106(b)(3). Additionally, the Provider has not exhausted all available remedies prior to appeal of this issue.

Issue No. 3 – DSH Medicaid Eligible Days

The MAC has challenged jurisdiction over the DSH Medicaid Eligible Days issue in its March 2, 2023 Jurisdictional Challenge. The MAC argues the Provider has abandoned the DSH Medicaid Eligible Days issue when it failed to properly develop their arguments in the preliminary position paper in accordance with Board Rule 25.[10] The MAC adds that the Provider has failed to provide a list of additional Medicaid eligible days or any other supporting documents regarding this issue and has failed to explain why it cannot produce these documents. The MAC indicates it requested the required documentation from the Provider regarding the DSH Medicaid Eligible Days issue on three separate dates – April 30, 2016, February 6, 2019, and January 18, 2023.[11]

Issue No. 4 – Uncompensated Care Distribution Pool

In the MAC's jurisdictional challenge dated April 5, 2019, the MAC contends the Board does not have jurisdiction over the Uncompensated Care Distribution Pool issue because judicial and administrative review of this issue is barred by statute and regulation. Because both 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) prohibit review of the Uncompensated Care Compensation Pool issue, the MAC asserts the issue should be dismissed. The MAC cites to *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health and Human Serv., 830 F.3d 515 (D.C. Cir. 2016)* in support of this argument. The MAC also adds that this issue in this

[9] Provider's Preliminary Position Paper at 8-9 (July 16, 2019).
[10] Medicare Contractor's Jurisdictional Challenge (March 2, 2023) at 1 - 4.
[11] Medicare Contractor's Jurisdictional Challenge (Mar. 2, 2023) at 4-7. *See also* Jurisdictional Challenge Ex. C-1.

individual appeal is duplicative of the same issue for this Provider in Group Case Nos. 15-1134GC and 16-0769GC, which were previously dismissed by the Board as they lacked jurisdiction over the issue as judicial review of this issue is barred by statute and regulation.

Provider's Response

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

Board Analysis and Decision

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

A. Issue 1 – DSH SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1involves the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage. This issue concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[12] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[13] The Provider argues that "the SSI percentage published by CMS [the Centers for Medicare and Medicaid Services] was incorrectly computed . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[14]

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[15] For cost issues relating to the DSH payment

[12] Individual Appeal Request, Tab 3 – Appealed Issues, Issue 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rule 7 (Aug. 29, 2018).

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.[16]

The Provider's Issue 2 for DSH Payment/SSI Percentage issue in group Case No. 19-1503GC 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 issue in Case No. 19-1503GC. 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, is pursuing that issue as part of the group under Case No. 19-1503GC (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] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific' errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1503GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. 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.[19]

Board Rule 25 states the requirements for preliminary position papers:

> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers *must* include the

[16] PRRB Rules 8.1 and 8.2 (Aug. 29, 2018).
[17] PRRB Rules v. 2.0 (Aug. 2018)
[18]
[19] (Italics emphasis added)

elements addressed in the following subsections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, *state the material facts that support the provider's claim.*

C. *Identify the controlling authority*, (e.g. statutes, regulations, policy or, case law) *supporting the provider's position*.

D. *Provide a conclusion applying the material facts to the controlling authorities*.

25.2 Position Paper Exhibits

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, *explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*.

Once the documents become available, promptly forward them to the Board and the opposing party.[20]

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

(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;

[20] (Italics emphasis added)

(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.

Finally, as explained in the Commentary to Board Rule 23.3, the Board requires position papers "to be *fully* developed and include *all available* documentation necessary to give the parties a thorough understanding of their opponent's position." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 and explain the nature of the any alleged provider-specific "errors" in its Preliminary Position Paper and include *all* exhibits. In particular, the Preliminary Position Paper did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1503GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds the Provider's Preliminary Position Paper failed to comply with Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the commentary to Board 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,[21] or why that it even relevant to the issue. Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. 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

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

> to hospitals will be the *same data set* CMS uses to calculate the Medicare fractions for the Federal fiscal year.[22]

Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.**[23] This CMS webpage describes access to DSH data *from 1998 to 2017* as follows: "DSH is now a self-service application. This *new self-service process* enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[24]

The Provider in this appeal offers no material facts or evidence pertaining to its FYE 04/30/2016 DSH SSI Percentage data errors, either in its appeal request or in its preliminary position paper. It is also noted that the Provider did not file a final position paper in this appeal (as the appeal was filed after August 2, 2018, the final position paper was optional).

Accordingly, based on the record before it,[25] the Board finds that Issue 1 in the instant appeal and the group issue from Group Case No. 19-1503GC are the same issue. Moreover, the Provider has failed to properly develop the merits of Issue 1 in compliance with Board Rule 25.2.2 and 42 C.F.R. § 405.1853(b)(2) because the Provider's preliminary position paper did not set forth the relevant facts and arguments regarding the merits of this Provider's claims with regards to the DSH SSI Percentage data errors aspect of Issue 1. The Board also finds that the Provider has abandoned the DSH SSI Percentage data errors issue by filing a perfunctory position paper that did not include any discussion or analysis of the MedPAR data files that are available to providers. Based on these multiple and independent bases the Board dismisses the first aspect of Issue 1 from the appeal.

2. Second Aspect of Issue 1

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

---

[22] 70 FR 47277, 47439 (Aug. 12, 2005).
[23] Last accessed March 14, 2023.
[24] Emphasis added.
[25] 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.

B. Issue 3 – 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:

> 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 C.F.R. § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.
>
> Audit Adjustment Number(s): 5, 6, 27, S-D. *See* Tab 4.
> Estimated Reimbursement Amount: $31,000. *See* Tab 5.[26]

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

On August 20, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[27] As of the filing of the second jurisdictional challenge on March 2, 2023, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days, though their Calculation Support filed with the position paper notes a net impact of $31,490, with an increase in days. To date, the Provider has not responded to the challenge alleging the listing was not submitted as required, nor has the Board been notified by either party that the listing was eventually submitted.

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

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible

[26] Individual Appeal Request, Issue 3.
[27] Provider's Preliminary Position Paper (July 16, 2019) at Exhibit 1.

> for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[28]

In its jurisdictional challenge, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $31,000, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper.

Board Rule 7.3.2. (Aug. 2018) states:

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

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

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

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[29]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[30]

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

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

Similarly, with regard to position papers,[31] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[32] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

---

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

[30] (Emphasis added).

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

[32] (Emphasis added).

> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[33]

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

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

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

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

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

> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
> • upon failure of the provider or group to comply with Board procedures (see 42 C.F.R. § 405.1868),
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[34] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the

[33] (Emphasis added).
[34] (Emphasis added).

Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days in dispute and the actual amount in controversy is $0 for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[35]

C. Issue 4 – DSH Uncompensated Care ("UCC") Payment Distribution Pool

The Board finds that the Provider previously filed appeals of this issue in the FFY 2015 and FFY 2016 Federal Register appeals of the same issue, and those appeals were previously adjudicated by the Board. The Provider was included in the appeal request in both Case Nos. 15-1134GC (appealing from the Fed. Reg. dated Aug. 22, 2014) and 16-0769GC (appealing from the Fed. Reg. dated Aug. 17, 2015). Both CIRP Group appeals were dismissed as the Board found it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). The Board hereby dismissed the Uncompensated Care issue from the appeal as it is a duplicate of the issue raised in 15-1134GC and 16-0769GC. As such, the Board hereby dismisses Issue 4 as a prohibited duplicate appeal of a common issue that was previously pursued as part of a CIRP group. Regardless, the Board would otherwise dismiss Issue 4 since 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude Board review of Issue 4.

****

In summary, based on the record before it, the Board hereby dismisses:

1. The DSH Payment/SSI Percentage (Provider Specific) issue from appeal because it is duplicative of the issue in PRRB Case No. 19-1503GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to properly develop the issue to establish it as a separate and distinct issue;

2. The DSH – Medicaid Eligible Days issue because the Provider failed to meet the Board requirements for preliminary position papers for this issue as described at 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rule 25; and

3. The UCC Distribution Pool issue as the issue is duplicative of the issues raised in 15-1134GC and 16-0769GC, both of which the Board previously dismissed.

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

In making these dismissals, the Board notes that the Provider failed to respond to the relevant Jurisdictional Challenges. This appeal is now closed as there are no remaining issues.

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:

8/15/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Starke Hospital (Provider Number 15-0102)
FYE: 12/31/2016
Case Number: 20-0867

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. 20-0867*

On August 22, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end December 31, 2016.

On January 24, 2020, 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[2]
4. Uncompensated Care Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

As the Provider is commonly owned/controlled by the health care chain, Community Health Systems, Inc. ("CHS"), the Provider is subject to the mandatory common issue related party ("CIRP") group regulation at 42 C.F.R. § 405.1837(b)(1). Accordingly, on August 19, 2020, the Provider transferred Issues 2 and 5 to CHS CIRP groups. As a result of these transfers, and two

[1] On August 19, 2020, this issue was transferred to PRRB Case No. 19-1409GC.
[2] This issue was withdrawn on March 2, 2023.
[3] This issue was withdrawn on May 4, 2021.
[4] On August 19, 2020, this issue was transferred to PRRB Case No. 19-1410GC.

issue withdrawals, the remaining issue in this appeal is Issue 1 (the DSH – SSI Percentage (Provider Specific).

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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 Payment/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 September 15, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

[5] Issue Statement at 1 (Jan. 24, 2020).
[6] *Id*. at 2.

> **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 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 amount in controversy for the issue is $2,554. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 19-1409GC.

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 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.

[7] Provider's Preliminary Position Paper at 8-9 (Sept. 15, 2020).

> . . .
>
> 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]

Provider's Jurisdictional Response

The Provider did not file a response to the Jurisdictional Challenge and the 30-day time frame to respond under Board Rule 44.4.3 has lapsed.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (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.

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that

[8] Jurisdictional Challenge at 6-7 (Dec. 29, 2020).
[9] *Id*. at 4-6.
[10] Issue Statement at 1.
[11] *Id.*

"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 Percentage (Systemic Errors) issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH Payment/SSI Percentage (Systemic Errors) issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[13], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and to that end, the Provider is pursuing that issue as part of the group under Case 19-1409GC. 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. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

---

[12] *Id.*

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

[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 the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[15]

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

> "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

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

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. As no issues remain pending, the Board hereby closes Case No. 20-0867 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:

8/16/2023

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Naples Community Hospital (Prov. No. 10-0018)
FYEs 09/30/2014, 09/30/2015
Case Nos. 17-1874, 18-1687

Dear Mr. Ravindran:

Naples Community Hospital ("Provider") filed Individual Appeal Requests with the Provider Reimbursement Review Board ("Board" or "PRRB") to establish Case No. 17-1874 on July 17, 2017 for fiscal year ("FY") 2014[1] and Case No. 18-1687 on August 31, 2018 for FY 2015.[2] The Provider's designated representative is James Ravindran at Quality Reimbursement Services ("QRS"). In these two cases, there are two issues remaining: (1) DSH/SSI Percentage (Provider Specific) and (2) DSH Medicaid Eligible Days.

The Provider failed to appear at its April 11, 2023 hearing for these two cases. ***On April 13th***, *without recognizing that it was two days* ***after*** *the hearing date*, QRS file a *post-hoc* motion to postpone the hearing. Specifically, QRS "request[ed] that the [Board] hearing … currently scheduled for April 11, 2023, be postponed finalizing the last remaining item in order to execute an Administrative Resolution." After review of the Provider's *post-hoc* hearing postponement request, the Board issued to QRS an Order to Show Cause as to why these cases should not be dismissed. On May 15, 2023, QRS filed the Provider's response to the Board's Show Cause Order. The Board's Ruling is set forth below.

Pertinent Facts and Law:

The regulation at 42 C.F.R. § 405.1849 addresses the setting of the time and place for a Board hearing:

> The Board shall fix the time and place for the hearing and shall send notice thereof to the parties' contact information on file, not less than 30 days prior to the scheduled time. Either on its own motion or for good cause shown by a party, the Board may, as

[1] The FY 2014 appeal pertains to the Notice of Program Reimbursement ("NPR") dated January 26, 2017.
[2] The FY 2015 appeal pertains to the NPR dated March 1, 2018.

> appropriate, reschedule, adjourn, postpone, or reopen the hearing, provided that reasonable written notice is given to the parties.

Board Rule 30.2 (Nov. 2021) specifies that the Board will dismiss a case if the provider fails to appear at a hearing, unless the provider can demonstrate good cause beyond its control, stating:

> **30.2 Dismissing for Failure to Appear**
>
> Except for good cause beyond a provider's control, the Board will dismiss a case if the provider fails to appear at the hearing.[3]

Board Rule 30.3 (Nov. 2021) addresses motions to postpone and requires that they be filed at least 20 days prior to hearing except for good cause. Specifically, this Rule states, in pertinent part:

> **30.3 Submitting a Motion to Postpone the Hearing**
>
> 30.3.1 **General**
>
> The Board will consider, but will not routinely grant, any motion requesting to postpone a scheduled hearing date. The Board expects the parties to be ready for hearing. The representation that a settlement is imminent or probable will not guarantee a postponement. A recent change in representatives or the late filing of a motion will generally not warrant the Board granting a postponement for either party. The Board expects the parties to be diligent in planning and preparing for hearing and disfavors last minute postponement requests. Accordingly, the Board expects motions for postponement to be filed *no later than 20 days prior to hearing*, except when a party establishes good cause.
>
> 30.3.2 **Request Content**
>
> A motion for postponement must be filed in compliance with Rule 2 and contain the following:
>
> - The reason the party[ies] are not ready for hearing.
> - An explanation (including dates and events) of how the parties have worked together to settle or narrow the issues.
> - A list of the actions needed to be ready for hearing.
> - Whether both parties concur in the Motion.
> - A proposed month and year in which to reschedule the case.

[3] (Bold emphasis in original.)

> NOTE: A motion for postponement pending before the Board that has not yet been completed or ruled upon will not suspend either the hearing date or any pre -hearing filing deadlines (*e.g.*, position papers, witness lists). If a motion for postponement is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with the hearing date and all filing deadlines.[4]

As background, in these two cases (as well as a third case[5]), on Tuesday, August 9, 2022, QRS requested postponement of the initially scheduled hearing date due to a change in authorized representative, and an employment change at the Provider. *At that time*, QRS indicated that it *would be submitting* a listing of additional days along with support for those days to the Medicare Administrative Contractor ("MAC") "***at the end of that week***," *i.e.*, by Friday, August 12, 2022.[6] QRS represented that, following the listing, the next 4 steps would be to then "receive a sample, submit support for the sample, finalize the audit review/adjustments and draft an administrative resolution" and requested a 180-day postponement to permit it to accomplish those steps. The Board granted the 180-day postponement request and rescheduled the hearing for Thursday, March 9, 2023.

On January 31, 2023, QRS requested a second postponement and represented that, *during the prior 5½ months*, it had submitted the list of days to the MAC (which had been promised to be sent by August 12, 2023) and then received a sample from the MAC. It is unclear from the January 31, 2023 request when QRS received that sample (or even how large the sample is) and when QRS began pulling the supporting documentation for that sample. However, QRS did state that, "[a]s of January 31, 2023, the Provider is in communication with the MAC to have the final supporting documentation submitted ***within the next couple of days***."[7] To this end, QRS stated that "[t]he MAC is in agreement with a ***short*** postponement of the hearing" and, thereby, requested that the Board postpone the hearing 30 days.

For each case, by letter dated February 1, 2023, the Board issued a Notice of Rescheduled Hearing that granted the Provider the 30-day postponement to Tuesday, April 11, 2023. In each case, the Notice that "[t]he above hearing date is firm and will be rescheduled only on the Board's own initiative" and that "[f]ailure to appear without a finding of good cause will result in dismissal of the case with prejudice."[8]

Pursuant to Board Rule 30.3.1, the deadline for QRS to file a request to postpone the hearing for these 2 cases was *20 days **prior to** the April 11, 2023 hearing*, *i.e.*, Wednesday, March 22, 2023.

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[4] (Underline emphasis added and italics and bold emphasis in original.)
[5] The other case for the Provider was Case No. 19-2188 for FY 2016 but that case was later closed after: (1) the Provider withdrew ***the Medicaid Eligible days issue (Issues 6)*** and the uncompensated care distribution pool issue (Issue 8) on October 19, 2022; and (2) the Board dismissed the remaining issue (Issue 1 for the DSH SSI Percentage, Provider Specific issue) by letter dated January 3, 2023.
[6] (Emphasis added.)
[7] (Emphasis added.)
[8] The notice further states that "[t]he parties' representatives and witnesses are expected to appear in person unless the Board approves an alternate forum."

However, QRS did not file a postponement request by that deadline or even *prior to* the April 11th hearing. Further, the Provider did not appear at the April 11th hearing.

Rather, two days *after* the hearing date, on Thursday April 13, 2023, QRS filed a *post-hoc* motion for postponement that covered *both* Case Nos. 17-1874 and 18-1687. In the *post-hoc* postponement motion, QRS asserted that the parties had anticipated executing an Administrative Resolution *prior to* the April 11th hearing date, as supported by the MAC's last agreement to the short 30-day postponement request. QRS explained that, when it originally purchased the State Eligibility Verification listing from the state, a copy was never sent directly to the MAC due to a change in state policy of which QRS claims it was not aware. At some point, apparently QRS became aware or learned of this error and then QRS purchased another copy to be sent directly to the MAC. However, as of April 13, 2023 (2½ months after QRS had requested the 30-day extension and stated that the file was being sent in "the next couple of days"), the MAC was still pending receipt of the file. QRS explained that this is what necessitated the need for another postponement. Notwithstanding the directive in Board Rule 30.3 that Motions for Postponement include "[a]n explanation (including dates and events) of how the parties have worked together to settle or narrow the issues", QRS did not give ***any*** *dates* for the above actions such as when it purchased the state eligibility listing, when it learned that this listing was not transmitted to the MAC, when it purchased the second listing, or when it communicated with the MAC regarding any of these actions.

QRS indicated that the next steps were for the MAC to be in receipt of the State Eligibility Verification listing from the state, to finalize the audit review/adjustments, and then to draft an administrative resolution. QRS stated that the MAC agreed with the postponement of the hearing.

On May 1, 2023, the Board issued an Order to Show Cause as to why the Board should not dismiss these two cases. In ordering QRS to Show Cause, the Board noted the following issues and deficiencies:

> Board Rule 30.3.1 requires hearing postponement requests to be filed *no later than 20 days prior to hearing*, and Board Rule 30.3.2 requires the content to include the reason the parties are not ready for hearing, including dates and events. Further, the Board noted that this case has been pending for 5¾ years and at this late date, *the record still does* ***not*** *contain a list of Medicaid eligible days notwithstanding the facts that the Provider filed its final position paper more than 10 months ago and th*e period for filing exhibits has closed per Board Rule 25. Finally, it was unclear when the Provider or QRS initiated getting a State Eligibility Verification listing **because no dates were given**. However, the Provider's final position paper filed on June 22, 2022 indicated that a listing of Medicaid eligible days was not included but claimed it was "being sent under separate cover."[9]

[9] (Emphasis added.)

On May 16, 2023, QRS responded to the Order to Show Cause and provided additional information that was ***not*** included in its April 13, 2023 *post-hoc* hearing postponement request:

> QRS *anticipated filing an Administrative Resolution for the above two referenced cases* prior to the hearing, but due to changes at the State in processing Medicaid Verification requests this delayed the audit. As a result, the two cases are currently stalled pending the MAC directly receiving the Medicaid Verification listings.
>
> On April 03, 2023, the State of California declared California Severe Winter Storms, straightline winds, Flooding, Landslides, and Mudslides from the period February 21, 2023, and continuing. Due to the numerous and devastating storms, the employee responsible for filing postponement requests was displaced due to the recent storms. On March 28, 2023, the employee had to vacate the premises of their home and home office for remediation including computer equipment that was destroyed. Damage amounted to approximately $23,000. As a result of this displacement and significant damage, *the employee filed a postponement request in an untimely fashion*. QRS has been consistent in responding to the numerous postponement requests due to Covid-19, but unfortunately, the deadlines for these two cases were inadvertently missed due to the events described above.
>
> ***On December 6, 2022***, *QRS submitted additional day listings of Medicaid Days to the MAC.* FYE 2014 contained an additional 359 days which amounted to an approximate impact of $68,000, and FYE 2015 contained an additional 587 days which amounted to an approximate impact of $53,000.
>
> ***On December 7, 2022****, the MAC submitted sample requests* for the submitted listings and requested additional information. QRS followed up ***on January 31, 2023****, to confirm receipt of the submitted supporting additional documentation for FYE 2015 and to also provided a status on the FYE 2014* UB request since additional time was needed. *On that same day, the MAC stated FYE 2015 will be ready for review later in the week and once the FYE 2014 data is submitted they will make it a priority to conduct their review*. ***Shortly after***, *the final FYE 2014 data was submitted to the MAC*. ***On March 14, 2023***, *the MAC responded with their final review for FYE 2014 and noted that they can not complete the review for FYE 2014 and FYE 2015 until the issue of receiving eligibility from the state is resolved*.

QRS then requested that these cases not be dismissed for the reasons indicated, and instead, that the cases be granted a *post-hoc* postponement for 90 days. Significantly, QRS did not explain why the listing of additional Medicaid eligible days was not submitted until December 6, 2022 notwithstanding the fact that, as noted above, QRS had represented 4 months earlier (on Tuesday, August 9, 2022) that this listing along with support for those days would be sent to the MAC "***at the end of <u>that</u> week***," *i.e.*, by Friday, August 12, 2022.[10] Similarly, it is unclear why QRS did not request a postponement on or shortly after March 14, 2023 when the MAC made clear that they could not complete the FYs 2014 and 2015 review due to the lack of state eligibility information, given that the deadline for requesting a postponement of the hearing was just a week later on March 22, 2023 (*i.e.*, 20 days prior to the April 11, 2023 hearing date). Moreover, QRS failed to clarify "*when the Provider or QRS initiated getting a State Eligibility Verification listing* ***because no dates were given***" and, as a result, it remains unclear when the following events happened during the 3 month period between December 7th and March 14th: (a) when QRS initially submitted its eligibility verification to the State of California for the sample given by the MAC for FYs 2014 and 2015; (b) when it learned that the requested information had not been sent to the MAC; and (c) when it resubmitted its eligibility verification request to the State of California for FYs 2014 and 2015.

Finally, the Board notes that these cases have 2 remaining issues but the correspondence from QRS only mentions the Medicaid eligible days issues for FYs 2014 and 2015. Specifically, it does not discuss or mention *the other remaining issue* in these cases, namely the SSI Provider Specific issue. As a result, it is unclear that the Parties have discussed resolution of this issue or whether the Provider had planned to withdraw/abandon the SSI Provider Specific issue for FYs 2014 and 2015.

<u>Board Determination</u>:

Pursuant to the regulation at 42 C.F.R. § 405.1868, the Board has full power and authority to make rules, not inconsistent with the law and regulations and confirms the Board may take remedial action, including dismissing an appeal, for failure to meet a deadline or other requirement ordered by the Board. In pertinent part, 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.

[10] (Emphasis added.)

> (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 regulation at 42 C.F.R. § 405.1849 addresses the setting of the time and place for a Board hearing:

> The Board shall fix the time and place for the hearing and shall send notice thereof to the parties' contact information on file, not less than 30 days prior to the scheduled time. Either on its own motion or for good cause shown by a party, the Board may, as appropriate, reschedule, adjourn, postpone, or reopen the hearing, provided that reasonable written notice is given to the parties.

The Board may dismiss an appeal due to a Provider's failure to appear for a scheduled hearing pursuant to Board Rule 30.2 (Nov. 1, 2021), which states that "[e]xcept for good cause beyond a provider's control, the Board will dismiss a case if the provider fails to appear at the hearing."

As described above, prior to the Board taking action after the Provider failed to appear at the hearing, and two days ***after*** *the date of the scheduled hearing*, the Provider filed a *post-hoc* request that the hearing be postponed. With regard to a request for postponement, Board Rule 30.3.1 states:

> The Board will consider, but will ***not*** routinely grant, any motion requesting to postpone a scheduled hearing date. The Board expects the parties to be ready for hearing. *The representation that a settlement is imminent or probable will* ***not*** *guarantee a postponement*. A recent change in representatives or the late filing of a motion will generally not warrant the Board granting a postponement for either party. *The Board expects the parties to be* ***diligent*** *in planning and preparing for hearing and disfavors last minute postponement requests*. Accordingly, the Board expects motions for postponement to be filed ***no later than 20 days prior to hearing***, except when a party establishes good cause.[11]

The content requirements for a request for hearing postponement are outlined in Board Rule 30.3.2 as follows:

[11] (Emphasis added.)

> A motion for postponement must be filed in compliance with Rule 2 and contain the following:
>
> - The reason the party[ies] are not ready for hearing.
> - An explanation (including dates and events) of how the parties have worked together to settle or narrow the issues.
> - A list of the actions needed to be ready for hearing.
> - Whether both parties concur in the Motion.
> - A proposed month and year in which to reschedule the case.

In accordance with Board Rule 30.3.1, the request for postponement was due no later than Wednesday, March 22, 2023, *i.e*., *20 days* ***prior to*** *the hearing date of April 11, 2023*. While QRS gave an explanation why the filing was late, the Board finds that explanation deficient. Accordingly, QRS has failed to establish good cause for filing the request 22 days after the Wednesday, March 22, 2022 filing deadline, established by Board Rule 30.3.1. Further, QRS has *failed* to present *any cause* to file the *post-hoc* request *2 days after the hearing date*. Board Rule 30.3.1 clearly states that "the Board expects motions for postponement to be filed ***no later than 20 days prior to hearing***, except when a party establishes good cause"[12] and that, "[t]*he representation that a settlement is imminent or probable will* ***not*** *guarantee a postponement*."[13] In this regard, the Board takes administrative notice that it has denied hearing postponement requests for failing to timely file the request 20 days prior to the hearing in compliance with Board Rule 30.3.1[14] and indeed, as recently as November 3, 2022, admonished QRS for failing comply with Board Rule 30.3.1 and ordered QRS to review *and* come into compliance with that Rule.[15]

---

[12] (Emphasis added.)

[13] (Emphasis added.)

[14] *See, e.g*., Case No. 16-1016 (Board letter dated Nov. 29, 2022 denying hearing postponement request stating "The Board notes that the postponement request was received eleven (11) days prior to the scheduled hearing. Upon review of the request, the Board finds that the Provider has *failed* to demonstrate good cause for failing to file the request no later than 20 days prior to the hearing as required by Rule 30.3.1 and therefore denies the request."); Case No. 16-1763 (Board letter dated Jan. 19, 2022 denying request to postpone hearing based, in part on the following: "Despite the Board Staff's request for the Provider's Representative to "indicate what efforts have been made toward a resolution since the last request for postponement[,]" the Second Postponement Request is void of ***any*** explanation, much less any dates and times, related to what efforts have been made to settle this issue since its last correspondence with the Board. Nor did the request contain any information that would establish good cause for the belated filing pursuant to Board Rule 30.3.1. Indeed, the Provider's intended actions were the exact same that the Provider stated in July 2021 with the update of "As of January 14, 2022" and, thereby, suggests that no actions had been taken during the past 6 months . . . . Like the First Postponement Request, the Second Postponement Request fails to confirm whether the Provider consulted with the Medicare Contractor about the postponement and whether the Medicare Contractor concurs with that request." (footnote omitted));

[15] Case No. 17-1581 (Board letter dated Nov. 3, 2022 stating "*The Board* ***admonishes*** *QRS for the* ***glaring*** *misrepresentation in the* ***original*** *postponement that the parties were ready to "finalize" an AR and for its failure to include, per Board Rule 30.3.2, to include "[a]n explanation (including dates and events) of how the parties have worked together to settle or narrow the issues."* The fact that QRS was recently designated as the Provider's representative for this case is *not* an excuse for its failure to accurately describe the status of this case and for its failure to include *both* dates *and* events of how the parties have worked to settle or narrow the issues. As a result, the Board directs QRS to review Board Rule 30.3 governing Motions for Postponement and to come into compliance with that

First, the Provider's response to the Show Cause Order fails to address, much less acknowledge, the March 22nd filing deadline. Instead, the Provider's response to the Board's Order to Show Cause focuses on events that occurred after the March 22nd postponement request deadline. QRS focuses on the events of March 28, the date of the employee's evacuation, and April 3, the date on which the state of California declared Severe Winter Storms. While the state's declaration indicates severe weather began at the end of February, again, QRS failed to give the precise date of the event that caused the employee's Tuesday, March 28th evacuation and, as such, the Board must assume it occurred on that day (*i.e.*, March 28th). However, the filing deadline for filing the hearing postponement request was on Wednesday, March 22nd, 6 days ***prior to*** March 28th. Moreover, QRS' response to the Board's Order to Show Cause shows that at least 8 days prior to the March 22nd postponement deadline, it was clear to the Provider that a postponement was needed. QRS stated that "[o]n March 14, 2023, the MAC responded with their final review for FYE 2014 and noted that they can not complete the review for FYE 2014 and FYE 2015 until the issue of receiving eligibility from the state is resolved."[16] As such, it is unclear why QRS failed to file its postponement request by the March 22nd deadline and QRS has failed to establish good cause for missing that filing deadline.

Second, the Provider's response to the Show Cause fails to establish why the Designated Representative, Mr. Ravindran, was unable to meet the March 22nd deadline. As noted above, the stated reasons for missing the March 22nd postponement deadline all occurred after the due date and involved an unnamed employee, not Mr. Ravindran. Specifically, QRS asserts that on March 28, 2023 (6 days after the March 22nd deadline), an unnamed employee responsible for filing postponement requests was displaced from his/her home for remediation including computer equipment destroyed. As a result of this displacement, the employee filed a postponement request in an untimely fashion. This explanation leaves many unanswered questions such as what was Mr. Ravindran, the official designated representative, doing relative to the administrative resolution process, the postponement request and preparation for the impending hearing. As noted in Board Rule 5.2 and 5.3, the case representative (*i.e.*, Mr. Ravindran) is responsible for meeting the Board's deadlines and failure of the case representative to carry out his/her responsibilities is not considered good cause for failure to meet any deadlines:

> **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

Rule. . . . If QRS continues in its failure to comply with this Rule, the Board may take additional remedial action such denial of postponement requests and reviewing the sufficiency of filings for potential dismissal. Notwithstanding, *as a <u>one-time</u> courtesy*, the Board hereby **grants** the request for postponement and extends the hearing for six (6) months from the original hearing date of November 11, 2022." (underline emphasis added, italics and bold emphasis in original, and footnotes omitted)).

[16] QRS April 13, 2023 *post-hoc* hearing postponement request.

> • 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.
>
> **5.3 Communications with Providers**
>
> The Board's communications will be sent to the case representative via email to the case representative's email address on file with the Board (*see* Rule 5.2). The Board will address notices only to the official case representative. Accordingly, the Board recommends that case representatives regularly check their email (including any filtered email) to ensure they do not miss important information related to their pending case(s) (*e.g.*, notice of Board deadlines, Board rulings or decisions, or documents filed by other parties). If other members of the case representative's organization contact the Board, the Board will assume the contact is authorized by the case representative and may communicate with those individuals about an appeal. In teleconferences with the Board or in hearings, the case representative may be assisted by others outside of his/her organization.[17]

Presumably, Mr. Ravindran, the designated case representative, would be responsible both for the discussions with the MAC regarding the potential resolution of these 2 cases *as well as* ensuring that QRS is either prepared and ready for the upcoming hearing or timely filing the postponement request (whether by himself or by someone at his direction).[18] In this regard, the

[17] (Underline emphasis added and italics and bold emphasis in original.)
[18] QRS has a large docket before the Board and, as such, is responsible for appropriate support and staffing to meet its obligations and responsibilities under the Board Rules.

Board notes that the "case actions" tab in OH CDMS for these two cases included an open case action for the upcoming hearing on April 11th (*i.e*., showing that it was active and had not been postponed) and similarly a check of the proceedings tab for these two cases would have shown that no postponement request had been filed had the designated case representative been monitoring these cases. Notwithstanding, the request for hearing postponement was not filed until two days ***after the April 11 hearing date***, and it is unclear why Mr. Ravindran could not timely file the hearing postponement request.

Third, if the March 28th displacement was, in fact, the reason for the late filed postponement request and for missing the hearing, why was this information not disclosed to the Board in the April 13, 2023 *post-hoc* postponement request? The Board does not believe it is based on what has been presented. The April 13th request for postponement itself does not mention any of the storm damage and evacuation issues or give any indication that there were such problems that prevented any filings. Rather the request for postponement focuses on *administrative issues* with requesting and obtaining information from the state. These administrative issues raised in the April 13th request do ***not*** constitute good cause for a postponement, much less the filing the postponement request 2 days *after the hearing date* and more than 22 days after the deadline for filing a postponement request.

Fourth, based on the new information shared in the April 13th *post-hoc* postponement request and the May 16th response to the Show Cause Order, it is apparent to the Board that QRS has mismanaged this case and has not been forthcoming and transparent with the Board regarding its efforts and diligence on these 2 cases. Case No. 17-1874 has been pending for over 6 years, (since July 17, 2017) and Case No. 18-1687 has been pending for almost 5 years (since August 31, 2018) and involve fiscal years 2014 and 2015 respectively, which both ended over 8 years ago. Moreover, the Board has already postponed the hearing for these two cases two times yet neither case has in the record before the Board a listing of the actual Medicaid eligible days in dispute.[19] QRS has not provided any reason why the Medicaid eligible days listing identifying the days in dispute was not provided with the final position papers filed in Case Nos. 17-1874 and 18-1687 on June 22, 2022.[20] Indeed, 1½ months later, in its postponement request dated

[19] Indeed, the Board *only* learned in QRS' May 16, 2023 response to the Show Cause Order that the Provider maintains there are 359 days at issue for FY 2014 and 587 days at issue for FY 2015. Per 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rules 27.2 and 25, the Provider was required to identify the days in dispute and provide supporting documentation in its final position paper because that information is "the relevant facts" for this issue and goes to the heart of "the merits of the provider's Medicare payment claim[] for . . . [the] remaining issue." Quoting 42 C.F.R. § 405.1853(b)(2). Under Board Rules, the submission of that information and documentation after the final position paper filings would generally not be accepted into the record unless the opposing party agreed to enter it into the record. *See also* Board Rule 35.3 (stating "Except on agreement of the parties, documentary evidence relevant to fact disputes must be identified and exchanged by the deadline established in the PJSO or by these rules."); 42 C.F.R. § 412.106(b)(4)(iii) (stating "The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.").

[20] The following are examples of cases where (1) the MAC requested that the Board dismiss the Medicaid eligible days issue because QRS failing to identify and include a listing of the specific Medicaid eligible days at issue in its position paper filing and, thereby, failed to properly develop the merits of the Medicaid eligible days issue in its position paper in compliance with Board Rules and regulations; and (2) following those motions, the Board dismissed the Medicaid eligible days issue consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board

August 9, 2022, QRS requested postponement of the initially scheduled hearing date due to a change in authorized representative, and represented that it *would be submitting* the promised listing of additional days along with support for those days to the MAC "***at the end of <u>that</u> week***," *i.e*., by Friday, August 12, 2022.[21] However, QRS did not honor that representation; instead submitting that listing to the MAC ***over 4 months later*** on December 22, 2022 (which the Board first learned in QRS' May 16th response to the Show Cause Order). It is unclear why QRS was unable to share the listing with the MAC prior to that late date, and why it still has not entered into the records for these cases a redacted listing of the specific days at issue. Based on the above concerns, the Board can only presume that QRS is mismanaging the case. The Board *admonishes* QRS for failing to be transparent and provide this information in its January 31, 2023 postponement request.

The Board hereby denies the *post-hoc* hearing postponement request. The Board finds that the *post-hoc* hearing postponement request did not present good cause to grant the request both for the reasons discussed above, and consistent with the February 1, 2023 Notice of Rescheduled Hearing for these cases, Board Rules 30.2 and 30.3, and 42 C.F.R. §§ 405.1868(b) and 405.1849.[22] The Provider, through its representative Mr. Ravindran at QRS, has mismanaged these cases, has failed to properly develop the record before the Board, failed to appear at the hearing, and has not shown good cause as to why these cases should not be dismissed.[23] Accordingly, the Board hereby dismisses Case Nos. 17-1874 and 18-1687 with prejudice. 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.

<u>Board Members</u>:

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

For the Board:

8/16/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. (J-N)

Rule 25: Case No. 14-2674 (Board dismissal dated May 5, 2022); Case No. 16-2521 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (Board dismissal dated May 5, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (Board dismissal dated Sept. 30, 2022); Case No. 21-1723 (Board dismissal dated Nov. 21, 2022); Case No. 16-1016 (Board dismissal dated Nov. 29, 2022); Case No. 17-1747 (Board dismissal dated Nov. 29, 2022); Case No. 15-2294 (Board dismissal dated Dec. 20, 2022); Case No. 20-2155 (Board dismissal dated Dec. 30, 2022); Case No. 16-2131 (Board dismissal dated dated Feb. 10. 2023); Case No. 21-1765 (Board dismissal dated Feb. 22, 2023); Case No. 22-0719 (Board dismissal dated Mar. 8, 2023).

[21] (Emphasis added.)

[22] *See Lester E. Cox Med. Ctrs. v. Sebelius*, 691 F. Supp. 2d 162 (D.D.C. 2010).

[23] *See Evangelical Community Hosp. v. Becerra*, No. 21-cv-01368, 2022 WL 4598546 (D.D.C. Sept. 30, 2022).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **–Medicaid eligible days**
Bristol Hospital (Prov. No. 07-0029, FYE 09/30/2013)
Case No. 16-2382

Dear Mr. Ravindran and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB or Board") reviewed the documentation in Case No. 16-2382 involving Bristol Hospital ("Provider") for fiscal year ("FY") 2013 in response to a Motion to Dismiss filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 16-2382

On September 9, 2016, the Provider filed a timely Individual Appeal Request from a Notice of Program Reimbursement ("NPR") for FY 2013 dated March 14, 2016, challenging (amongst other issues) the Medicare Contractor's inclusion of Medicaid eligible days in its applicable cost report. The sole remaining issue in this appeal is the Medicaid eligible days issue as all other issues in the appeal were either transferred to group appeals or dismissed.

On April 28, 2017, the Provider filed its preliminary position paper and, similarly, on August 24, 2017, the Medicare Contractor filed its preliminary position paper. On July 7, 2022, the Provider filed its final position paper and, similarly, on August 8, 2022, the Medicare Contractor filed its final position paper.

On March 03, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid eligible days issue (the sole remaining issue) in the above-referenced appeal. The Provider failed to timely reply to the Motion to dismiss with in the 30-day period allowed under Board Rule 44.3.

Rather than responding to the Motion to Dismiss, on March 6, 2023 (3 days after the deadline), the Provider filed a request to postpone the April 6, 2023 hearing in the above-referenced appeal "to give the parties sufficient time to ***finalize*** an Administrative Resolution."[1] It is unclear on

[1] (Emphasis added.)

what basis the Provider had to suggest that the parties were finalizing (much less discussing) an Administrative Resolution given the Motion to Dismiss filed 4 weeks earlier.

On March 9, 2023, the Medicare Contractor filed an objection to the Provider's Postponement Request and renewed its request for dismissal. At no point, did the Medicare Contractor suggest that the parties had been finalizing or discussion an Administrative Resolution.

B. Description of Issue in the Appeal Request

In its Individual Appeal Request received on September 9, 2016, the Provider summarizes the Medicaid eligible days issue as follows:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instruction 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 processes after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[2]

On July 7, 2022, the Provider filed its Final Position Paper setting forth the following position on the Medicaid eligible days issue:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b) (4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs*., 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state,

[2] Provider's September 9, 2016 Appeal Request, Tab 3-Appeal Issues, Issue 7.

> should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated.
>
> The Centers for Medicare and Medicaid Services . . . acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2013 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[3]
>
> ****
>
> The Provider requests that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable. Further, upon completion of that review, the Provider requests that the MAC administratively resolve this issue by computing the Medicaid Fraction using patient days applicable to all Medicaid eligible patients to comply with the decisions of the Federal Courts and HCFAR 97-2.[4]

Exhibit 1 in the Provider's Final Position Paper provides: "**Eligibility Listing** [for FYE September 30, 2013] (NOT INCLUDED—BEING SENT UNDER SEPARATE COVER)."[5]

On September 9, 2022, the Provider filed a request to postpone its hearing scheduled for October 7, 2022. In its Postponement Request, the Provider asserted:

> As of September 09, 2022, the Provider is *finalizing a listing* for submission to the MAC. Due to employee turnover, the gathering of the required support and data for submission has taken longer than anticipated. The next steps are to receive and submit support

[3] Provider's July 7, 2022 Final Position Paper at 7-8.
[4] *I*d. at 10.
[5] *Id.* at 10-11.

> for the sample, finalize the audit review/adjustments and draft an administrative resolution.[6]

The hearing was postponed. On March 6, 2023, the Provider yet filed another request to postpone the hearing which was scheduled for April 06, 2023.[7] In its Postponement Request, the Provider asserts:

> 1. As of March 6, 2023, due to employee turnover, the gathering of the required support and data for submission has taken longer than anticipated. However, since the last postponement request a CPA firm has been assigned to cover the functions of the director of reimbursement roll. As such, they are working to provide the necessary data required for submission to the MAC.
>
> 2. ***The next step is to submit a listing***, receive and submit support for the sample, finalize the audit review/adjustments and draft an administrative resolution.[8]

The above request makes clear that, even though the appeal had been pending roughly 6½ years and the fiscal year had been closed for roughly 8½ years, the Provider still had not identified and created a listing of Medicaid eligible days at issue in this case.

Medicare Contractor's Contention

The Medicare Contractor requests that the Medicaid eligible days issue be dismissed from the appeal. The Provider promised in both its preliminary and final position papers that the Medicaid eligible days listing of days was being sent under separate cover and included an Exhibit 1 stating "ELIGIBILITY LISTING NOT INCLUDED-TO BE EMAILED SEPARATELY." Yet more than five years has passed since the Provider submitted its Preliminary Position Paper, and over a year has passed since it filed its Final Position Paper, and at no time did the Provider submit a listing for review.

The Medicare Contractor represents that it also sent emails on June 28, 2017, and August 24, 2017 to the Provider and QRS requesting a listing of the additional Medicaid eligible days at issue. Similarly, on September 8, 2022, in response to the Provider's request for postponement of the hearing, the Medicare Contractor sent an email to QRS with a *final* request for the listing of Medicaid eligible days at issue. The Medicare Contractor asserts to date, despite the representation in the Provider's Preliminary and Final Position Papers, the Provider has failed to respond to the Medicare Contractor's request for documentation and has otherwise failed to tender to the Medicare Contractor an eligibility listing or necessary documentary support for the additional Medicaid eligible days to which it asserts it is entitled.[9]

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[6] Provider's September 9, 2022 Postponement Request at 1 (emphasis added).
[7] Pursuant to Board Order 3 and Alert 23.
[8] Provider's March 6, 2023 Postponement Request at 1 (emphasis added).
[9] Provider's March 3, 2023 Motion to Dismiss at 1-2.

The Medicare Contractor maintains Providers have the affirmative duty and burden to supply all required documentation and State validation of any additional Medicaid eligible days being claimed, which the Provider has failed to do over 77 months since the appeal was filed. The Medicare Contractor concludes that the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of Board Rules 7, 27.2, 25.2.1 and 25.2.2. The Medicare Contractor requests that the Board find that the Provider has effectively abandoned its claim for additional Medicaid eligible days and dismiss the Provider's claim for additional Medicaid eligible days.[10]

Provider's Response

The Provider did ***not*** file a response to the Medicare Contractor's Motion to Dismiss. Board Rule 44.3 specifies: "[u]nless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision

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

In the instant case, for the sole remaining issue (Medicaid eligible days), the Board finds that the Provider failed to include the listing of the additional Medicaid eligible days that it expects to be included in its Medicaid percentage and DSH computation with its Individual Appeal Requests. The Provider filed a Preliminary and Final Position Paper in the above-referenced appeal in which it promised that the listing of additional Medicaid eligible days would "be[] sent under separate cover." However, the Provider has failed to submit the promised listing of additional Medicaid eligible days.

Board Rule 7.1 B **No Access to Data** (July 1, 2015) provides:

> 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.

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.

[10] *Id*. at 3-5.

The Board finds that the Provider's position papers did not include supporting documentation nor describe why the underlying information is unavailable,[11] nor state the efforts the Provider has made to obtain the documents which are missing and/or remain unavailable in accordance with Board Rule 25.2(B) **Unavailable and Omitted Preliminary Documents** which provides:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

Notably, the Provider has not included a list of additional Medicaid eligible days with its Preliminary or Final Position Paper in the above-referenced case or submitted such a list under separate cover. The Board finds 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.[12]

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*.[13]

The Board finds with regard to position papers,[14] Board Rule 25.2(A) (as also applied to final position papers through Board Rule 27) requires that "the parties must exchange ***all*** *available*

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[11] The Board recognizes that, in its postponement requests the Provider alleged employee turnover causing delays. However, that explanation was not included in the Final Position Paper filing and, regardless, is too vague to meet the Board Rule 25.2 requirements. Similarly, the appeal request includes a vague general statement that not all Medicaid patient eligibility is available from the State at the time of filing its appeal in 2016. However, that statement is irrelevant to the final position paper filed years later in July 2022.

[12] *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.

[13] (Emphasis added).

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

documentation as preliminary exhibits to fully support your position."[15] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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.

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[16] 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 in the above-referenced appeal. Nor has the Provider provided an explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2 notwithstanding the facts that the appeal had been pending roughly 6½ years and the fiscal year had been closed for roughly 8½

[15] (Emphasis added).
[16] (Emphasis added).

years. Indeed, without any days identified in the Preliminary and Final Position Paper ***filings with the Board***, the Board must assume that there are no days in dispute and that the actual amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[17]

****

As such, the Board dismisses the Medicaid eligible days issue in Case No. 16-2382 as the Provider failed to meet the Board requirements for position papers for this issue and has essentially abandoned the issue. In so finding, the Board takes administrative notice that it has made similar dismissals in many other cases in which QRS was the designated representative.[18]

As no issues remain pending in the above-referenced case, the Board closes Case No. 16-2382 and removes the case 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:

8/17/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[17] Board Rule 25 is applicable to final position papers via Board Rule 27.2.

[18] Examples of QRS-represented individual provider cases which the Board similarly dismissed the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16-2521 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filing dated Mar. 2, 2022); Case No. 17-1747 (dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 15-2294 (dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Jan. 20, 2023).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **–Medicaid eligible days**
Bristol Hospital (Prov. No. 07-0029, FYE 09/30/2012)
Case No. 16-0931

Dear Mr. Ravindran and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB or Board") reviewed the documentation in Case No. 16-0931 involving Bristol Hospital ("Provider") for fiscal year ("FY") 2012 in response to a Motion to Dismiss filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. *Procedural History for Case No. 16-0931*

On February 8, 2016, Bristol Hospital ("Provider"), Provider No. 07-0029, fiscal year ending ("FYE") September 30, 2014, filed a timely Individual Appeal Request from a Notice of Program Reimbursement ("NPR") dated August 12, 2015, challenging (amongst other issues) the Medicare Contractor's inclusion of Medicaid eligible days in its applicable cost report. The sole remaining issue in this appeal is the Medicaid eligible days issue as all other issues in the appeal were transferred to group appeals or dismissed.

On September 28, 2016, the Provider filed its preliminary position paper. Similarly, on May 21, 2018, the Medicare Contractor filed its preliminary position paper. On July 7, 2022, the Provider filed its final position paper. Similarly, on August 8, 2022, the Medicare Contractor filed its final position paper.

On March 6, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid eligible days issue (the sole remaining issue) in the above-referenced appeal. On that same date, Bristol Hospital filed a request to postpone the April 6, 2023 hearing in the above-referenced appeal "to give the parties sufficient time to ***finalize*** an Administrative Resolution."[1] It is unclear on what basis the Provider had to suggest that the parties were finalizing (much less discussing) an Administrative Resolution given the Motion to Dismiss filed the same day. Significantly, the Provider failed to timely reply to the Motion to dismiss with in the 30-day period allowed under Board Rule 44.3.

[1] (Emphasis added.)

On March 9, 2023, the Medicare Contractor filed an objection to the Provider's Postponement Request and renewed its request for dismissal. At no point, did the Medicare Contractor suggest that the parties had been finalizing or discussion an Administrative Resolution.

B. ***Description of Issue in the Appeal Request***

In its Individual Appeal Request received on February 8, 2016, the Provider summarizes the Medicaid eligible days issue as follows:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processes after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[2]

On July 7, 2022, the Provider filed its Final Position Paper setting forth the following position on the Medicaid eligible days issue:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b) (4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs*., 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state,

[2] Provider's February 8, 2016 Appeal Request,Tab 3-Appeal Issues, Issue 7.

> should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated.
>
> The Centers for Medicare and Medicaid Services . . . acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2012 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[3]
>
> ****
>
> The Provider requests that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable. Further, upon completion of that review, the Provider requests that the MAC administratively resolve this issue by computing the Medicaid Fraction using patient days applicable to all Medicaid eligible patients to comply with the decisions of the Federal Courts and HCFAR 97-2.[4]

Exhibit 1 in the Provider's Final Position Paper provided: "**Eligibility Listing** [for FYE September 30, 2012] (NOT INCLUDED—BEING SENT UNDER SEPARATE COVER)."[5]

On September 09, 2022, the Provider filed a request to postpone its hearing scheduled for October 07, 2022. In its Postponement Request, the Provider asserts:

> As of September 09, 2022, the Provider is *finalizing a listing* for submission to the MAC. Due to employee turnover, the gathering of the required support and data for submission has taken longer than anticipated. The next steps are to receive and submit support for the

[3] Provider's July 7, 2022 Final Position Paper at 7-8.
[4] *I*d. at 10.
[5] *Id*. at 11.

> sample, finalize the audit review/adjustments and draft an administrative resolution.[6]

The hearing was postponed. On March 6, 2023, Bristol Hospital filed another request to postpone the hearing which was scheduled for April 06, 2023.[7] In its Postponement Request Bristol Hospital asserts:

> 1. As of March 6, 2023, due to employee turnover, the gathering of the required support and data for submission has taken longer than anticipated. However, since the last postponement request a CPA firm has been assigned to cover the functions of the director of reimbursement roll. As such, they are working to provide the necessary data required for submission to the MAC.
>
> 2. *The next step is to* ***submit a listing***, receive and submit support for the sample, finalize the audit review/adjustments and draft an administrative resolution.[8]

The above request makes clear that, even though the appeal had been pending over 7 years and the fiscal year had been closed for roughly 10½ years, the Provider still had not identified and created a listing of Medicaid eligible days at issue in this case.

Medicare Contractor's Contentions

The Medicare Contractor requests that the Medicaid eligible days issue be dismissed from the appeal. In its September 28, 2016 Preliminary Position Paper, Bristol Hospital included a listing of 503 additional Medicaid days under Exhibit 1. On November 16, 2016, the Medicare Contractor sent an email to Bristol Hospital requesting an electronic version of the Medicaid days listing that was included in the Provider's Preliminary Position Paper. On November 18, 2016, a representative of QRS acting on behalf of the Provider, submitted the electronic listing, however, the listing did not contain all necessary information needed for the Medicare Contractor's review.

The Medicare Contractor asserts that Bristol Hospital failed to specify in its Final Position Paper the number of additional Medicaid eligible days to which it contends it is entitled but rather, included a statement under its Exhibit 1 that the Eligibility Listing was not included and was being sent under separate cover. On April 29, 2020, and August 10, 2022, the Medicare Contractor emailed Bristol Hospital and QRS, requesting a listing of the additional Medicaid eligible days at issue in an auditable format which was referenced in Exhibit 1 of its Final Position Paper. On September 8, 2022, in response to the Provider's request for postponement of the hearing, the Medicare Contractor emailed QRS with a final request for the listing of Medicaid eligible days at issue. To date, despite the representation in Bristol Hospital's Final

[6] Provider's September 9, 2022 Postponement Request at 1 (emphasis added).
[7] Pursuant to Board Order 3 and Alert 23.
[8] Provider's March 6, 2023 Postponement Request at 1 (emphasis added).

Position Paper, the Provider has failed to respond to the Medicare Contractor's request for documentation and has otherwise failed to tender to the MAC an auditable eligibility listing or necessary documentary support for the additional Medicaid eligible days to which it asserts it is entitled.[9]

The Medicare Contractor maintains Providers have the affirmative duty and burden to supply all required documentation and State validation of any additional Medicaid eligible days being claimed, which the Provider has failed to do over 85 months which have elapsed since the appeal was filed. The Medicare Contractor argues this passage of time and the failure to respond to the Medicare Contractor's multiple requests for documentation, belies the Provider's affirmative statement in its Final Position Paper that an eligibility listing was being sent to the Medicare Contractor under separate cover. The Medicare Contractor concludes that the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of Board Rules 7, 27.2, 25.2.1 and 25.2.2. The Medicare Contractor requests that the Board find that the Provider has effectively abandoned its claim for additional Medicaid eligible days and dismiss the Provider's claim for additional Medicaid eligible days.[10]

Provider's Response

The Provider did *not* file a response to the Medicare Contractor's Motion to Dismiss. Board Rule 44.3 specifies: "[u]nless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2016), 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.

In the instant case, for the sole remaining issue (Medicaid eligible days), the Board finds Bristol Hospital failed to include the listing of the additional Medicaid eligible days that it expects to be included in its Medicaid percentage and DSH computations with its individual appeal requests. Bristol Hospital filed a Final Position Paper in the above-referenced appeal in which it promised that it would be sending the Medicaid eligibility listing under separate cover. The Medicare Contractor recognizes that the Provider included a listing of 503 additional Medicaid days in an exhibit attached to its September 28, 2016 preliminary position paper but contends that the listing was ***not*** *auditable* because the listing did not contain all of the necessary information needed for the Medicare Contractor's review. The Board finds the Medicare Contractor's contention persuasive. At that time only the first page of preliminary position papers were required to be filed with the Board and, as a result, the Provider did not enter into the Board's

[9] Provider's March 6, 2023 Motion to Dismiss at 1-2.
[10] *Id*. at 4-5.

record the Exhibit referenced by the Medicare Contractor. However, the Provider then failed to file that listing (or any other Medicaid eligibility listing) 5½ year later, on July 7, 2022, with its Final Position Paper. Further, the Provider failed to respond to the Medicare Contractor's numerous emails requesting an auditable listing of the additional Medicaid eligible days. To date, the Board has not been notified by either party that the listings were submitted, and ***no*** such listing has *ever* been entered into the Board's record . Finally, the Provider failed to respond to the Medicare Contractor's Motion to Dismiss.

Board Rule 7.1 B **No Access to Data** (July 1, 2015) provides:

> 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.

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 Board finds that the Provider's position papers did not include supporting documentation nor describe why the underlying information is unavailable,[11] nor state the efforts the Provider has made to obtain the documents which are missing and/or remain unavailable in accordance with Board Rule 25.2(B) **Unavailable and Omitted Preliminary Documents** which provides:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

Notably, the Provider ***never*** filed an auditable list of additional Medicaid eligible days with its Final Position Paper in the above-referenced case or filed such list under separate cover. The Board finds 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.[12]

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

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[11] The Board recognizes that, in its postponement requests the Provider alleged employee turnover causing delays. However, that explanation was not included in the Final Position Paper filing and, regardless, is too vague to meet the Board Rule 25.2 requirements. Similarly, the appeal request includes a vague general statement that not all Medicaid patient eligibility is available from the State at the time of filing its appeal in 2016. However, that statement is irrelevant to the final position paper filed years later in July 2022.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[13]

The Board finds with regard to position papers,[14] Board Rule 25.2 A requires that "the parties must exchange ***all*** *available* documentation as preliminary exhibits to fully support your position."[15] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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.

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

> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned,

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[13] (Emphasis added).
[14] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[15] (Emphasis added).

> • upon failure of the provider or group to comply with Board procedures,
> • if the Board is unable to contact the provider or representative at the last known address, or
> • upon failure to appear for a scheduled hearing.

The Board concurs with the Medicare Contractor that, as part of its final position paper filing, the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 (as applied via Board Rule 27). 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"[16] 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 an auditable listing or other supporting documentation for the Medicaid eligible days issue as required by the controlling regulations and Board Rules in the above-referenced appeals. Nor has the Provider provided an explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2 notwithstanding the facts that the appeal had been pending over 7 years and the fiscal year had been closed for roughly 10½ years. Indeed, without any days identified in the Final Position Paper filing, the Board must assume that there are no days in dispute and that the actual amount in controversy is $0.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25 (as applied through Board Rule 27) 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.[17]

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As such, the Board dismisses the Medicaid eligible days issue in Case Nos. 16-0931 as the Provider failed to meet the Board requirements for position papers for this issue. In so finding, the Board takes administrative notice that it has made similar dismissals in many other cases in which QRS was the designated representative.[18]

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[16] (Emphasis added).
[17] Board Rule 25 is applicable to Final Position Papers via Board Rule 27.2.
[18] Examples of QRS-represented individual provider cases which the Board similarly dismissed the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16-2521 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12, 2021 respectively); Case No. 21-1723 (dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filing dated Mar. 2, 2022); Case No. 17-1747 (dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filing dated Oct.

As no issues remain pending in the above-referenced case, the Board closes Case Nos. 16-0931 and removes the case 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:

8/17/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

17, 2022); Case No. 15-2294 (dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Jan. 20, 2023).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– Medicaid Eligible Days**
Bristol Hospital (Prov. No. 07-0029, FYE 09/30/2014)
Case No. 16-1781

Dear Mr. Ravindran and Ms. Decker:

The Provider Reimbursement Review Board ("PRRB or Board") reviewed the documentation in Case No. 16-1781 involving Bristol Hospital ("Provider") for fiscal year ("FY") 2014 in response to a Motion to Dismiss filed by the Medicare Contractor ("MAC"). The Board's decision is set forth below.

Background

A. Procedural History for Case No. 16-1781

On June 3, 2016, the Provider filed a timely individual Appeal Request from the lack of a timely Notice of Program Reimbursement ("NPR") for FY 2014 challenging (amongst other issues) the Medicare Contractor's inclusion of Medicaid eligible days in its applicable cost report. On September 26, 2017, the Provider filed a second Individual Appeal Request from the FY 2014 NPR dated March 29, 2017. On September 29, 2017, the Board incorporated the NPR based appeal into the appeal based on the lack of a timely NPR. The sole remaining issue in this appeal is Medicaid eligible days as all other issues in the appeal were transferred to group appeals or dismissed.

On January 31, 2017, the Provider filed its preliminary position paper and, on May 22, 2022, the Medicare Contractor filed its preliminary position paper. On December 29, 2017, the Provider filed a supplemental preliminary position paper and, on April 26, 2018, the Medicare Contractor filed a supplemental preliminary position paper.

On July 7, 2022, the Provider filed its final position paper. Similarly, on August 8, 2022, the Medicare Contractor filed its final position paper.

On March 5, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid eligible days issue (the sole remaining issue) in the appeal. The Provider failed to timely reply to the Motion to dismiss with in the 30-day period allowed under Board Rule 44.3.

Rather than responding to the Motion to Dismiss, on March 6, 2023 (3 days after the deadline), the Provider filed a request to postpone the April 6, 2023 hearing in the above-referenced appeal "to give the parties sufficient time to ***finalize*** an Administrative Resolution."[1] It is unclear on what basis the Provider had to suggest that the parties were finalizing (much less discussing) an Administrative Resolution given the Motion to Dismiss filed 4 weeks earlier.

On March 9, 2023, the Medicare Contractor filed an objection to Bristol's Postponement Request and renewed its request for dismissal. At no point, did the Medicare Contractor suggest that the parties had been finalizing or discussion an Administrative Resolution.

B. Description of Issue in the Appeal Requests

The Provider summarizes the Medicaid eligible days issue in its June 3, 2016 Appeal Request based on a lack of a timely NPR as follows:

> **Statement of Issue**
>
> The Provider was unable to include all Disproportionate Share Hospital ("DSH")/Medicaid Eligible Days on its' cost report as not all Medicaid patient eligibility is available at the time of filing from the State.
>
> **Statement of the Legal Basis**
>
> **II. DSH/Medicaid Eligible Days**
>
> The Provider was unable 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 as all the State Medicaid eligibility data was not available at the time of cost report filing.[2]

In the Provider's September 26, 2017 NPR based Appeal Request it asserts:

> **Statement of Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the statutory instructions

[1] (Emphasis added.)
[2] Provider's June 3, 2016 Individual Appeal Request, Issue 3.

> 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 processes after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation. [3]

On July 7, 2022, the Provider filed its Final Position Paper setting forth the following position on the Medicaid eligible days issue:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's calculation of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b) (4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs*., 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated.
>
> The Centers for Medicare and Medicaid Services . . . acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible days being sent under separate cover, the Provider contends that the total number of days reflected in its 2014 cost report does not reflect an accurate number

[3] Provider's September 26, 2017 Second Individual Appeal Request, Tab 3 Appeal Issues, Issue 7.

> of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.[4]
>
> ****
>
> The Provider requests that the MAC review the Medicaid eligible days listing being sent under separate cover and provide a sample listing as soon as practicable. Further, upon completion of that review, the Provider requests that the MAC administratively resolve this issue by computing the Medicaid Fraction using patient days applicable to all Medicaid eligible patients to comply with the decisions of the Federal Courts and HCFAR 97-2. [5]

Exhibit 1 in the Provider's Final Position Paper provides: "**Eligibility Listing** [for FYE September 30, 2014] (NOT INCLUDED—BEING SENT UNDER SEPARATE COVER)."[6]

On September 09, 2022, Bristol Hospital filed a request to postpone its hearing scheduled for October 07, 2022. In its Postponement Request Bristol Hospital asserts:

> As of September 09, 2022, the Provider is *finalizing a listing* for submission to the MAC. Due to employee turnover, the gathering of the required support and data for submission has taken longer than anticipated. The next steps are to receive and submit support for the sample, finalize the audit review/adjustments and draft an administrative resolution.[7]

The Hearing was postponed. On March 6, 2023, Bristol Hospital filed another request to postpone its hearing which was scheduled for April 6, 2023.[8] In its Postponement Request Bristol Hospital asserts:

> 1. As of March 6, 2023, due to employee turnover, the gathering of the required support and data for submission has taken longer than anticipated. However, since the last postponement request a CPA firm has been assigned to cover the functions of the director of reimbursement roll. As such, they are working to provide the necessary data required for submission to the MAC.
>
> 2. *The next step is to* ***submit a listing***, receive and submit support for the sample, finalize the audit review/adjustments and draft an administrative resolution.[9]

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[4] Provider's July 7, 2022 Final Position Paper at 7-8.
[5] *I*d. at 10.
[6] *Id*. at 10-11.
[7] Provider's September 9, 2022 Postponement Request at 1 (emphasis added).
[8] Pursuant to Board Order 3 and Alert 23.
[9] Provider's March 6, 2023 Postponement Request at 1.

The above request makes clear that, even though the appeal had been pending over 6½ years and the fiscal year had been closed for nearly 8½ years, the Provider still had not identified and created a listing of Medicaid eligible days at issue in this case.

Medicare Contractor's Contention

The Medicare Contractor requests that the Medicaid eligible days issue be dismissed from the appeal. The Provider promised in both its preliminary and final position papers that the Medicaid eligible days listing of days was being sent under separate cover and included an Exhibit 1 stating "ELIGIBILITY LISTING NOT INCLUDED-TO BE EMAILED SEPARATELY." Yet more than five years has passed since the Provider submitted its Preliminary Position Paper, and over a year has passed since it filed its Final Position Paper, and at no time did the Provider submit a listing for review.

The Medicare Contractor represents that it also sent emails on November 7, 2017 sent an email to Bristol Hospital requesting a listing of the additional Medicaid eligible days at issue and referenced in Exhibit 1 of its Preliminary Position Paper. Bristol Hospital responded on December 6, 2017, indicating that it intended to complete the final listing package and would provide it as soon as it is ready. The Medicare Contractor sent multiple emails to the Provider's Representative, QRS, between October 2018 and December 2019 requesting a status of the appeal. On September 8, 2022, in response to the Provider's request for postponement of the hearing, the Medicare Contractor sent an email to QRS with a final request for the listing of Medicaid eligible days at issue. The Medicare Contractor contends to date, despite the representations in Bristol Hospital's Preliminary and Final Position Papers, the Provider has failed to respond to the Medicare Contractor's request for documentation and has otherwise failed to tender to the Medicare Contractor an eligibility listing or necessary documentary support for the additional Medicaid eligible days to which it asserts it is entitled.[10]

The Medicare Contractor maintains Providers have the affirmative duty and burden to supply all required documentation and State validation of any additional Medicaid eligible days being claimed, which the Provider has failed to do over 81 months since the appeal was filed. The Medicare Contractor concludes that the Provider's failure to furnish such documentation (or describe why such documentation is unavailable) is in violation of Board Rules 7, 27.2, 25.2.1 and 25.2.2. The Medicare Contractor requests that the Board find that the Provider has effectively abandoned its claim for additional Medicaid eligible days and dismiss the Provider's claim for additional Medicaid eligible days.[11]

Provider's Response:

The Provider did *not* file a response to the Medicare Contractor's Motion to Dismiss. Board Rule 44.3 specifies: "[u]nless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

[10] Medicare Contractor's March 5, 2023 Motion to Dismiss at 1-2.
[11] *Id*. at 4-5.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final 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.

In the instant case, for the sole remaining issue (Medicaid eligible days), the Board finds that the Provider failed to include the listing of the additional Medicaid eligible days that it expects to be included in its Medicaid percentage and DSH computation with its Individual Appeal Requests. Bristol Hospital filed a Preliminary and Final Position Paper in the above-referenced appeal in which it promised that the listing of additional Medicaid eligible days would "be[] sent under separate cover." However, the Provider has failed to submit a list of additional Medicaid eligible days.

Board Rule 7.1 B **No Access to Data** (July 1, 2015) provides:

> 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.

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 Board finds that the Provider's position papers did not include supporting documentation nor describe why the underlying information is unavailable,[12] nor state the efforts the Provider has made to obtain the documents which are missing and/or remain unavailable in accordance with Board Rule 25.2(B) **Unavailable and Omitted Preliminary Documents** (July 1, 2015) which provides:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.

Notably, the Provider has not included a list of additional Medicaid eligible days with its Preliminary or Final Position Paper in the above-referenced case or submitted such a list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its

[12] The Board recognizes that, in its postponement requests the Provider alleged employee turnover causing delays. However, that explanation was not included in the Final Position Paper filing and, regardless, is too vague to meet the Board Rule 25.2 requirements. Similarly, the appeal request includes a vague general statement that not all Medicaid patient eligibility is available from the State at the time of filing its appeal in 2016. However, that statement is irrelevant to the final position paper filed years later in July 2022.

arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[13]
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*.[14]

The Board finds with regard to position papers,[15] Board Rule 25.2 A requires that "the parties must exchange ***all*** *available* documentation as preliminary exhibits to fully support your position."[16] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

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

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

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

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

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[13] *See also* the 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.
[14] (Emphasis added).
[15] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[16] (Emphasis added).

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[17] 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 in the above-referenced appeal. Nor has the Provider provided an explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2 notwithstanding the facts that the appeal had been pending over 6½ years and the fiscal year had been closed for nearly 8½ years. Indeed, without any days identified in the Preliminary and Final Position Paper filings, the Board must assume that there are no days or amounts in dispute 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. §§ 405.1853(b)(2)-(3) and 412.106(b)(iii) and Board Rules 25 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[18]

****

As such, the Board dismisses the Medicaid eligible days issue in Case No. 16-1781 as the Provider failed to meet the Board requirements for position papers for this issue and has essentially abandoned the issue. In so finding, the Board takes administrative notice that it has made similar dismissals in many other cases in which QRS was the designated representative.[19]

---

[17] (Emphasis added).
[18] Board Rule 25 is applicable to Final Position Papers via Board Rule 27.2.
[19] Examples of QRS-represented individual provider cases which the Board similarly dismissed the Medicaid eligible days issue include, but are not limited to: Case No. 14-2674 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 22, 2022); Case No. 16-2521 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case No. 16-0054 (dismissed by Board letter dated May 5, 2022 initiated by MAC filing dated Mar. 25, 2022); Case Nos. 13-3022, 13-3211, 14-2506, 14-4313, 16-1712 (dismissed by Board letter dated Sept. 30, 2022 initiated by MAC filing dated Dec. 10, 2020, Dec. 11, 2020, Mar. 12, 2021, Mar. 12, 2021, and Nov. 12,

As no issues remain pending in the above-referenced case, the Board closes Case No. 16-1781 and removes the case 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:

8/17/2023

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

2021 respectively); Case No. 21-1723 (dismissed by Board letter dated Nov. 21, 2022 initiated by MAC filing dated Sept. 1, 2022); Case No. 16-1016 (dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filing dated Mar. 2, 2022); Case No. 17-1747 (dismissed by Board letter dated Nov. 29, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 15-2294 (dismissed by Board letter dated Dec. 20, 2022 initiated by MAC filing dated May 23, 2022); Case No. 20-2155 (both issues dismissed by Board letter dated Dec. 30, 2022 initiated by MAC filing dated Oct. 17, 2022); Case No. 16-2131 (dismissed by Board letter dated Feb. 10. 2023 initiated by MAC filing dated Dec. 22, 2022); Case No. 21-1765 (dismissed by Board letter dated Feb. 22, 2023 initiated by MAC filing dated Dec. 6, 2022); Case No. 22-0719 (dismissed by Board letter dated Mar. 8, 2023 initiated by MAC filing Jan. 20, 2023).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244
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Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Tennova Healthcare-Lebanon (Prov. No. 44-0193)
FYE 10/31/2016
Case No. 19-1320

Dear Mr. Summar,

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

Background:

A. Procedural History for Case No. 19-1320

Tennova Healthcare Lebanon submitted a request for hearing on February 5, 2019, from a Notice of Program Reimbursement ("NPR") dated August 7, 2018. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage
- Issue 3: SSI Fraction Medicare Managed Care Part C Days
- Issue 4: SSI Fraction Dual Eligible Days
- Issue 5: DSH- Medicaid Eligible Days
- Issue 6: Medicaid Fraction Medicare Managed Care Part C Days
- Issue 7: Medicaid Fraction Dual Eligible Days
- Issue 8: Uncompensated Care ("UCC") Distribution Pool
- Issue 9: 2 Midnight Census IPPS Payment Reduction

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issues 2, 3, 4, 5, 7, 8 and 9.

On January 3, 2020, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. The Provider did not file a response to the MAC's Jurisdictional Challenge. Under Board Rule 44.4.3 a response was due within 30 days:

> 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*.[1]

On January 6, 2023, the Medicare Contractor filed its "Final Request for DSH Medicaid Eligible Days Support. However, the Provider did not file a response. Accordingly, on July 4, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3- DSH Medicaid Eligible Days. The Provider's representative, Community Health Systems ("CHS"), has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

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

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

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

The Provider was also transferred into a mandatory group under Case No. 19-0173GC entitled "*CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*." This CIRP group has the following issue statement:

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[1] (Emphasis added.)
[2] Provider's Request for Hearing, Issue Statement (Feb. 5, 2019)

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

Statement of the Legal Basis:

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

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

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

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

Calculation of the SSI Percentage

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 Fiscal Year End (October 31).

[3] See Group Issue Statement, PRRB Case no. 19-0173GC

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

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

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On January 3, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of an issue which was transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[4]

Issue 2 – DSH Medicaid Eligible Days

On July 4, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Paper stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 53 months since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[5]

[4] MAC's Jurisdictional Challenge, at 1.
[5] MAC's Motion to Dismiss.

Provider's Response

The Provider did not file a response to the Jurisdictional Challenge.

The Provider did not file a response to the Motion to Dismiss.

Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 19-0173GC which it was required to do since it is an issue common to all CHS providers and thereby subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1). The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[6] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees

[6] Individual Appeal Request, Issue 1.
[7] *Id.*

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."[8] The DSH systemic issues filed into Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-0173GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 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.[9] 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) in its appeal request of 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

[8] *Id.*

[9] 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).

> 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.[10] 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."[11]

Accordingly, based on the record before it,[12] the Board must find that Issues 1 and the group issue in Group 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 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting

[10] (Last accessed Nov. 21, 2022.)
[11] (Emphasis added.)
[12] Again, the Board notes that the Provider failed to respond to the Jurisdictional Challenged and, per Board Rule 44.4.3, the Board must make a ruling based on the record before it.

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on February 5, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, 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.[13]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the

[13] Provider's Appeal Request (Feb. 5, 2019).

> adjustment is correct, describe why the underlying information is unavailable.

However, when Community Health Systems ("CHS") filed the February 5, 2019 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[14]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[15] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*

[14] (Bold emphasis added.)
[15] (Bold emphasis added.)

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

24.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
>
> Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements

> **COMMENTARY:**
>
> The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.
>
> CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

On October 2, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[16] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:

[16] Provider's Preliminary Position Paper (October 2, 2019).

> [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $22,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[17]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[18] 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" [19] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on October 2, 2019 that "the Listing

---

[17] *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.

[18] 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.

[19] (Emphasis added.)

of Medicaid Eligible days [are] being sent under separate cover."[20] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. As such, the Board finds that the issue has been effectively abandoned since not even a single day has been identified as being in dispute, thereby rendering the actual amount in controversy as $0.

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

The Board also dismisses Issue 5, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the MAC as to the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. In dismissing Issue 5, the Board takes administrative notice that it has made similar dismissals in other cases in which CHS was the designated representative[21] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper and respond to the Motion to Dismiss.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

[20] Provider Preliminary Position Paper at 8.

[21] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Mat-Su Medical Center (Prov. No. 45-0340)
FYE 12/31/2016
Case No. 19-2378

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Contractor's Motion to Dismiss request. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 19-2378

Mat-Su Regional Medical Center submitted a request for hearing on August 6, 2019 from a Notice of Program Reimbursement ("NPR") dated February 27, 2019. The hearing request included the following issues[1]:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage
- Issue 3: DSH- Medicaid Eligible Days
- Issue 4: Uncompensated Care ("UCC") Distribution Pool
- Issue 5: 2 Midnight Census IPPS Payment Reduction

As the Provider is part of CHS and thereby subject to the mandatory common issue related party ("CIRP") group regulations at 42 C.F.R. § 405.1837(b)(1), it transferred Issues 2 and 5 to CIRP groups.

On May 13, 2020, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific and Issue 4- UCC Distribution Pool. The Provider filed a response to the MAC's Jurisdictional Challenge on May 18, 2020. However, on May 18, 2020, the Provider withdrew Issue 4.

As a result of these transfers and withdrawal, the sole remaining issues in this appeal are Issue 1 and 3.

[1] All issues but for Issue 1 and Issue 3 have been transferred to Common Issue Related Party ("CIRP") Group Appeals.

On March 27, 2020, the Provider filed its preliminary position paper. On July 31, 2020, the Medicare filed its preliminary position paper.

On January 4, 2023, the Medicare Contractor filed its 4th and Final Request for DSH package. The Provider did not file any response.

On June 21, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3- DSH Medicaid Eligible Days. The Provider's representative, Community Health Systems ("CHS"), has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

B. Description of Issue 1 in the Appeal Request & the Provider's Participation in Case No. 19-1409GC

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

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

The Provider was also transferred into a mandatory group under Case No. 19-1409GC entitled "*CHS CY 2016 DSH SSI Percentage CIRP Group*." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely

[2] Provider's Request for Hearing, Issue Statement (Aug. 6, 2019)

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

On March 27, 2020, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

Calculation of the SSI Percentage

Provider Specific

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

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

Similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to

[3] Group Issue Statement, Case No. 19-1409GC.

> analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On May 13, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of an issue which was transferred into Group Case No. 19-1409GC, *CHS CY 2016 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[4]

Issue 2 – DSH Medicaid Eligible Days

On June 21, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 3 years since the appeal was filed, even after following up repeatedly requesting a listing. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[5]

Provider's Response

The Provider filed a response to the Jurisdictional Challenge on May 18, 2020. The Provider contends Issue 1 represent different and separate components of the SSI Issue and request the Board to find jurisdiction over the DSH/SSI provider specific issue. The Provider cites to Board Rule 8.1, which states, "some issues may have multiple components. To comply with the regularity requirement to

[4] MAC's Jurisdictional Challenge, at 1.
[5] MAC's Motion to Dismiss.

specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…"[6]

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

Board Analysis and Decision:

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 19-1409GC, *CHS CY 2016 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 19-1409GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[7] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9] The DSH systemic issues filed into Case No. 19-1409GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

[6] Provider Response to MAC's Jurisdictional Challenge on May 22, 2018.
[7] Individual Appeal Request, Issue 1.
[8] *Id.*
[9] *Id.*

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-1409GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 19-1409GC. 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.[10] 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) in its appeal request of how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.[11] It is insufficient to simply respond to the jurisdictional challenge by saying the Provider "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio" without explaining what that belief is based on and not provide examples to differentiate this issue from the SSI Systemic issue which is common to all CHS providers.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;

[10] 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).

[11] In its response 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 errors that have been previously identified in the Baystate litigation." Yet in the very next sentence, the Provider says the opposite: "*Once patients are identified*, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage." (Emphasis added.) Due to the immediate contradiction and the fact that no examples have been provided, the Board must assume no such examples have actually been identified.

> 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.[12] 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."[13]

Accordingly, based on the record before it, the Board must find that Issues 1 and the group issue in Group 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

[12] (Last accessed Nov. 21, 2022.)
[13] (Emphasis added.)

2. Second Aspect of Issue 1

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on August 6, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient 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.[14]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

[14] Provider's Appeal Request (Aug. 6, 2019).

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

However, when Community Health Systems ("CHS") filed the August 6, 2019 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[15]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[16] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers

[15] (Bold emphasis added.)
[16] (Bold emphasis added.)

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

24.2.1 General

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

Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to Board

Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

On March 27, 2020, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[17] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir.

[17] Provider's Preliminary Position Paper (March 27, 2020).

> 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $39,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover or submitted such list under separate cover even after the MAC submitted a "4th and final" follow up request for the listing on January 4, 2023. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[18]

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[19] 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"[20] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on March 27, 2020 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[21] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. As such, the Board finds that the issue has been effectively abandoned since not even a single day has been identified as being in dispute, thereby rendering the actual amount in controversy as $0.

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

Similarly, the Board dismisses Issue 3, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding numerous follow up attempts to request the documentation and a follow-up Motion to Dismiss for failure to reply. In dismissing Issue 3, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or after numerous requests.[22]

---

[19] 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.
[20] (Emphasis added.)
[21] Provider Preliminary Position Paper at 8.
[22] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/18/2023

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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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

David Johnston, Esq.
Epstein, Becker & Green, P.C.
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Columbus, OH 43215

RE: ***Board Determination on Request for Reconsideration of Dismissal/Reinstatement***
Rush University Medical Center (Prov. No. 14-0119; FYE 6/30/2016)
Case No. 23-0319

Dear Mr. Johnston:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal in response to correspondence received from Epstein, Becker & Green, P.C. ("EBG"/ "Representative") on July 31, 2023, August 4, 2023, and August 9, 2023. In it, EBG requests that the Board reconsider the July 27, 2023 "Dismissal for Untimely Filing" and grant a reinstatement of the subject appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **November 28, 2022,** EBG filed the individual appeal on behalf of Rush University Medical Center (FYE 06/30/2016) under Case No. 23-0319. The appeal included two issues: Allied Health Program and Respiratory Therapy & Allied Health Program - Vascular Ultrasound.

On **December 1, 2022,** the Board issued the Case Acknowledgement and Critical Due Dates ("ACCD") Notice setting the Provider's preliminary position paper deadline for July 26, 2023 and the Medicare Contractor's for November 23, 2023.

On **January 27, 2023**, three additional issues were timely added: CPE Allied Health Program Reimbursement, HSM Allied Health Program Reimbursement and Direct Graduate Medical Education "Fellow Penalty."

On **March 28, 2023**, after Alert 19 was lifted, the Board issued an updated Critical Due Dates notification *reaffirming* the original preliminary position paper deadlines in the ACCD. The Notice further warned the Provider that failure to timely file the position paper:

> The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Provider misses any of its due dates, the Board will dismiss the appeal.

On **July 27, 2023**, the day after the expiration of the preliminary position paper deadline, the Board dismissed Case No. 23-0319 because EBG failed to timely file its position paper.
On **July 31, 2023**, EBG filed a request for reinstatement and explains that the subject case was "inadvertently" and in "error" removed from its internal docket calendaring system by administrative staff when the staff was directed to remove other appeals for this Provider for other fiscal years ("FYs"), namely for FYs 2009 to 2011. In support of its request, EBG included a copy of an internal email allegedly demonstrating that instruction had been given to staff directing them NOT to remove other years for the provider. EBG asserts that it intended to pursue the FY 2016 appeal, which is worth over $2.5 million, and it was only due to the staff's administrative error deleting the respective due dates, that it missed the preliminary position paper deadline.

In its reinstatement request, EBG explained that, in order to file a prompt reinstatement request, it was omitting the required preliminary position paper filing which is required under Rule 47.3, but advised that a preliminary position paper would be filed on August 4, 2023. In addition, EBG advised that, although it had attempted to obtain the Medicare Contractor's concurrence, it had not yet had an opportunity to discuss the request with the Medicare Contractor.

On **August 4, 2023**, EBG sent follow-up correspondence in which it advised that, " . . . due to staff absences and difficulty gathering exhibits at the Provider . . ." it would be filing the Preliminary Position Paper during the following week, at which time ". . . the request for reinstatement will then be ready for consideration by the Board."

On **August 9, 2023**, EBG filed a second copy of its July 31, 2023 request for reinstatement, to which it attached the required copies of the Preliminary Position Paper and Exhibits.

Board Determination:

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

EBG has filed a *motion* requesting that the Board reinstate the case.[1] Board Rule 47 governs motions for reinstatement of an issue or case and states the following, in pertinent part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the

[1] The initial reinstatement request was supplemented 9 days later, with a resubmitted copy of the original reinstatement request, that included the required preliminary position paper and exhibits that were the cause of the case dismissal.

> Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will ***not*** reinstate an issue(s)/case if the provider was *at fault*. If an issue(s)/case was remanded pursuant to a CMS ruling (*e.g.*, CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> *Upon written motion demonstrating good cause*, the Board <u>*may*</u> *reinstate* a case dismissed for failure to comply with Board procedures. <u>*Generally, administrative oversight*</u>, settlement negotiations or a change in representative *will <u>not</u> be considered good cause to reinstate*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[2]

Board Rule 47.1 states that the Board will not reinstate if the provider was at fault and Board Rule 47.3 further clarifies that, when the dismissal is based on the failure to comply with Board Procedures (such a filing a required position paper), the Board may reinstate for good cause which does ***not*** include administrative oversight. Here, the Board finds that the Provider was at fault and was due to administrative since the Representative failed to meet the preliminary position paper deadline due to its own error and inadvertence. Further, contrary to Board Rule 44 governing motions, EBG's initial motion for reinstatement did *not* include the Medicare Contractor's concurrence, nor did it include the required preliminary position paper filing. The preliminary position paper was not filed until nine (9) days later and, to date, the record still does not include the Medicare Contractor's concurrence.

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board denies EBG's request for reinstatement of Case No. 23-0319. The Board finds that the Representative is at fault and failed to establish good cause under Board Rules 47.1 and 47.3 as it admitted its fault, failed to provide the required Medicare Contractor's concurrence, and did not include the required preliminary position paper submission required by Board Rules 47.1 and 44. Therefore, the Board declines to exercise it discretion to reinstate Case No. 23-0319 and it thereby remains closed. The Board denial is consistent with numerous cases in which federal courts have upheld the Board's

[2] (Emphasis added.)

authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[3]

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

For the Board:

8/18/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Pamela Van Arsdale, National Government Services, Inc. (J-6)

[3] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board denial based on the); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV- 6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Brent Wilson
Quorum Health
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RE: ***Notice of Dismissal***
Vista Medical Center East (Prov. No. 14-0084)
FYE: 11/30/2015
Case No.: 18-1845

Dear Mr. Wilson,

The Provider Reimbursement Review Board ("Board or PRRB") received Vista Medical Center East ("Provider") Individual Appeal Request on September 17, 2018. On September 28, 2018, the Board sent the parties a Case Acknowledgement and Critical Due Dates letter setting the Provider's Preliminary Position Paper due date to May 15, 2019, and the Medicare Contractor's Preliminary Position Paper due date to September 12, 2019.

On May 7, 2019, the Provider filed its Preliminary Position Paper. On September 12, 2019, the Medicare Contractor filed its Preliminary Position Paper. On March 25, 2020, the Board issued Alert 19, which indefinitely suspended "Board-Set Deadlines" from Friday, March 13, 2020, forward and "encourage[d] Providers and their representatives to continue to make these filings electronically through OH CDMS, as appropriate and in keeping with public health precautions."[1]

On August 24, 2022, the Board issued a Notice of Hearing to the parties scheduling the hearing in Case No. 18-1845 for June 1, 2023, and scheduling the Provider's Final Position Paper due date on March 3, 2023, the Medicare Contractor's Final Position paper due date on April 2, 2023, and the Provider's optional responsive brief and Witness Lists due date on May 2, 2023.[2] On April 18, 2023, an email was sent to the parties by Board staff asking the parties to provide an update on the case and advise if the parties will be coming in for the live hearing scheduled for June 1, 2023. On April 24, 2023, a follow up email was sent to the parties as no response was received from the parties. On April 24, 2023, the Medicare Contractor through its representative, Scott Berends, responded to Board staff's email advising that the Provider had not filed its Final Position Paper; thus, dismissal of the Provider's appeal was appropriate. Board staff did not receive a response to its inquiry.

[1] *See also* Board Rule 4.1 & 41.2.
[2] Pursuant to Board Rule 27, the parties were not required to file Final Position Papers but only complete Preliminary Position Papers (see Rule 25.3). Final Position Papers are "optional" for new appeals filed on or after August 29, 2018.

On April 28, 2023, a Notice of Hearing-Final was issued to the parties because Alert 19 (which suspended Board filing deadlines) expired on December 7, 2022 (pursuant to Board Order 3 and Alert 23), rescheduling the hearing in Case No. 18-1845 to August 31, 2023, and rescheduling the Provider's Final Position Paper due date to June 2, 2023, the Medicare Contractor's Final Position Paper due date to July 2, 2023, and the Provider's optional responsive brief and Witness Lists due date to August 1, 2023. On June 16, 2023, the Medicare Contractor filed a Final Position Paper stating that it would rely on its previously submitted Preliminary Position Paper. The Provider did not file a Final Position Paper.[3]

On July 19, 2023, Board staff sent an email to the parties asking the parties to provide an update on the case and advise if the parties will be coming in for the live hearing scheduled for August 31, 2023. On July 25, 2023, a follow up email was sent to the parties asking the parties to respond by Friday, July 28, 2023, if they are coming in for the hearing as no response was received from the parties. On July 25, 2023, the Medicare Contractor's representative, Scott Berends, responded advising "FSS and the MAC are prepared to attend and participate in the hearing. I note that there is a pending jurisdictional challenge and that the Provider has not filed anything in this case since approximately April 2019. Correspondence to the Provider has gone unanswered as well."

On July 31, 2023, Board staff reached out to the Provider representative, Brent Wilson, at the phone number on file. Board staff spoke with staff at the Provider Representative's organization (Victoria Pointer and Stan Caldwell) Quorum Health, who advised Board staff that Brent Wilson no longer works for Quorum Health and further, that the Provider, Vista Medical Center East (Prov. No. 14-0084), is no longer owned by Quorum Health but was sold through a stock sale on June 30, 2023. Board staff requested that the Provider Representative organization submit a letter to the Board advising of the circumstances in the case and requesting a withdrawal of the appeal if they are no longer pursuing the case. Stan Caldwell of the Provider Representative's organization advised that Heather Mangeot, a staff member who handled Brent's cases, would contact Board staff *regarding the withdrawal*. To date, Board staff has not heard back from the Provider Representative organization and Witness Lists, which were due on August 1, 2023, were not submitted by the parties.

Board Rule 5.2 (Nov. 2021) addresses the Case Representative's responsibilities which include maintaining current contact information and timely responding to Board correspondence/requests:

> **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

[3] However, the Provider was not required to do so as the Final Position Paper filing was optional per Board Rule 27.

> • These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-andGuidance/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.

Board Rule 5.3 (Nov. 2021) addresses Board communications with Case Representatives:

> **5.3 Communications with Providers**
>
> The Board's communications will be sent to the case representative via email to the case representative's email address on file with the Board (see Rule 5.2). The Board will address notices only to the official case representative.

Board Rule 4.1 and 41.2 (Nov, 2021) permits dismissal or closure of a case on the Board's own motion:

> **4.1 General Requirements**
>
> The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements.
>
> **41.2 Own Motion**
>
> The Board may dismiss a case or an issue on its own motion:
>
> • if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
>
> • upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),
>
> • if the Board is unable to contact the provider or representative at the last known address, or

• upon failure to appear for a scheduled hearing.

Pursuant to 42 C.F.R. § 405.1868(b):

> (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

Based on the following, the Board has a reasonable basis to believe that the Provider has abandoned the 3 remaining issues in the appeal (SSI Percentage (Provider Specific) and Medicaid Eligible days and Standardized Amount):

- The lack of response from the Provider's Representative to Board inquiries,
- The failure of the Provider to comply with Board filing deadlines (failed to file its Witness List by the August 1, 2023 deadline),
- The Board's inability to contact the Provider Representative at the last known contact, in light of the upcoming hearing date of August 31, 2023,
- The limited activity or filings by the Provider since May 7, 2019 (when the Provider filed its Preliminary Position Paper),
- The Provider Representative staff's assertion that the Provider Representative, Brent Wilson, no longer works for Quorum Health and
- That Quorum Health no longer owns, the Provider, Vista Medical Center East, but sold Vista Medical Center East in a stock sale on June 30, 2023.
- The preliminary position paper ("PPP") filed in this case was perfunctory and failed to properly develop the merits of the 3 remaining issues in the case consistent with 42 C.F.R. §§ 405.1853(b)(2)-(3) and 412.106(b)(4)(iii) and Board Rule 25 and, indeed, this is an additional independent basis to dismiss this case:
    - The PPP did not properly develop the merits of the Medicaid eligible days issue as it failed to identify or list of actual Medicaid eligible days in dispute or explain why that information was not available.
    - The PPP the merits of the SSI provider specific issue as it failed to explain MedPAR data is not available consistent with Board Rule 25.2, including describing its efforts to obtain that data. In this regard, the Board notes that information related to the SSI percentage is available on line and a self-serve basis.[4]
    - The PPP failed to brief the standardized amount issue and, as such, it is considered abandoned per Board Rule 25.3.

[4] *See, e.g.*, **https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH** (last accessed Aug. 18, 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." (Emphasis added.)

As such, the Board hereby dismisses Case No. 18-1845 with prejudice and removes it from the Board's docket pursuant to its authority under 42 C.F.R. § 405.1868(b). Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
Bayfront Health Port Charlotte (Provider No. 10-0077)
FYE 12/31/2015
Case No. 19-0648

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. 19-0648*

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

On November 29, 2018, 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]
8. Uncompensated Care (UCC) Distribution Pool[6]
9. Two Midnight Census IPPS Payment Reduction[7]

[1] On June 13, 2019, this issue was transferred to Case No. 18-0588GC.
[2] On June 13, 2019, this issue was transferred to Case No. 18-0589GC.
[3] On June 13, 2019, this issue was transferred to Case No. 18-0584GC.
[4] On June 13, 2019, this issue was transferred to Case No. 18-0591GC.
[5] On June 13, 2019, this issue was transferred to Case No. 18-0585GC.
[6] On June 13, 2019, this issue was transferred to Case No. 18-0587GC.
[7] On June 13, 2019, this issue was transferred to Case No. 18-0592GC.

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 June 13, 2019, the Provider transferred Issues 2, 3, 4, 6, 7, 8, and 9 to CHS CIRP groups. As a result of these transfers, the sole remaining issues in this appeal are Issue 1 (the DSH – SSI Percentage (Provider Specific) issue) and Issue 5 (the DSH – Medicaid Eligible Days issue).

On July 23, 2019, the Provider filed its preliminary position paper.

On August 21, 2019, the Medicare Contractor 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, and the SSI alignment portion of the issue was premature and the Provider has not exhausted all available remedies. On September 17, 2019, the Provider filed a Response to the Jurisdictional Challenge arguing that the issues are not duplicative because the issues represent different components of the SSI issue. Further, the Provider stated the SSI realignment issue is appealable because the SSI Percentage was specifically adjusted.

On November 15, 2019, the Medicare Contractor filed its preliminary position paper.

On April 29, 2021, July 14, 2021, and January 2, 2023, the Medicare Contractor filed requests for the Provider to submit its DSH package. However, the Provider did not file a response to any of these requests. Accordingly, on May 16, 2023, the Medicare Contractor filed a Motion to Dismiss requesting that the Board dismiss Issue 5, as the Provider failed to furnish documentation in support of its claim in violation of Board Rules. Again, the Provider failed to file a response to the Motion to Dismiss even though a response was due within 30 days per Board Rule 44.3.

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

In their Individual Appeal Request, Provider summarizes its DSH – SSI 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.[8]

As the Provider is commonly owned by CHS, the Provider transferred its Issue – DSH SSI Percentage – to the CIRP group under Case No. 18-0588GC on June 13, 2019. The group issue in Case No. 18-0588GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> . . .
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days.[9]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $74,000.

[8] Issue Statement at 1 (Nov. 29, 2018).
[9] Group Issue Statement, Case No. 18-0588GC.

On July 23, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

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

C. Filings Concerning the Jurisdictional Challenge

1. MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

In its August 21, 2019 Jurisdictional Challenge, the MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a provider election. It is not a final MAC determination. The provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage.

> Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal of this item is premature. 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.[10]

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.[11]

Issue 5 – DSH – Medicaid Eligible Days

In its May 16, 2023 Motion to Dismiss, 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 July 23, 2019 preliminary position paper in violation of Board Rule 25.3. The MAC notes that it specifically requested this listing from the Provider on 3 different dates: April 29, 2019; July 14, 2021; and January 3, 2023. However, the Provider never responded to those requests. The MAC then requested the Board make the following findings and Order the following:

> a. That the Provider has failed to furnish documentation in supports of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
> b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
> c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.[12]
> d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days. . .[13]

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

---

[10] Jurisdictional Challenge at 6 (Aug. 21, 2019).
[11] *Id*. at 4-6.
[12] PRRB Rules v. 2.0 (Aug. 2018).
[13] Motion to Dismiss at 5 (May 16, 2023).

2. Provider's Jurisdictional Response

Issue 1 – DSH – SSI Percentage (Provider Specific)

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[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 2015, resulting from its understated SSI percentage due to errors of omission and commission."[16]

Issue 5 – DSH – Medicaid Eligible Days

The Provider did *not* file a response to the May 16, 2023 Motion to Dismiss regarding Issue 5 and the 30-day time frame to respond under Board Rule 44.4.3 has lapsed.

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (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. 18-0588GC.

[14] Jurisdictional Response at 1 (Sept. 17, 2019).
[15] *Id*. at 2.
[16] *Id*.

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[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 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. 18-0588GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH – SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH – SSI Percentage (Systemic Errors) issue in Case No. 18-0588GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[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 18-0588GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[21] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0588GC.[22] It is insufficient to simply respond to the jurisdictional challenge by saying the Provider "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio" without explaining what that belief is based on and not provide examples to differentiate this issue from the SSI Systemic issue which is common to all CHS providers.

---

[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 may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[22] In its response 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 errors that have been previously identified in the Baystate litigation." Yet in the very next sentence, the Provider says the opposite: "*Once patients are identified*, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage." (Emphasis added.) Due to the immediate contradiction and the fact that no examples have been provided, the Board must assume no such examples have actually been identified.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0588GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." 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.[23]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[24]

Accordingly, *based on the record before it*, the Board finds that Issue 1 and the group issue from Group Case 18-0588GC are the same issue. Because the issue is duplicative, and Board Rule 4.6 prohibits appealing duplicative issues \from the *same* final determination, the Board dismisses this component of the DSH – SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

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

B. Medicaid Eligible Days

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

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

> of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[25]

The Provider failed to include a list of additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations, with their appeal request. The Provider also failed to respond to the three requests for DSH package that the Medicare Contractor submitted.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[26] 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.[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

[25] Individual Appeal Request, Issue 5.
[26] Provider's Preliminary Position Paper at 8.
[27] *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.

> 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) (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,[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:

> *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:

---

[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).
[31] (Emphasis added).

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(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 has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it consistent with Board Rule 25.2 (B). Indeed, without any days being identified in the position paper filing, the Board assumes that there are no days and the actual amount in dispute is $0 for this issue.

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. 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

[32] (Emphasis added).
[33] (Emphasis added).

requirements of Board Rules 25.2 (A) and 25.2 (B) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[34]

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 CHS was the designated representative.[35] 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 Motion to Dismiss.

****

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. 18-0588GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the Medicaid eligible days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 19-0648 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:

8/18/2023

X Clayton J. Nix

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

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

[34] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.
[35] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathan Summar
Community Health Systems, Inc.
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Byron Lamprecht
WPS Government Health Administrators
2525 N 117th Ave., Suite 200
Omaha, NE 68164

RE: ***Motion to Dismiss Medicaid Eligible Days***
Western Arizona Medical Center (Prov. No. 03-0101)
FYE 08/31/2016
Case No. 19-0681

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 19-0681 in response to a Motion to Dismiss filed by the Medicare Contractor ("MAC"). The Board's is set forth below.

Background:

Community Health Systems, Inc. ("CHS") is the Provider's designated representative for this appeal. On December 6, 2018, CHS established Case No. 19-0681 on behalf of the Provider by filing the Provider's Individual Appeal Request appealing their June 6, 2018, Notice of Program Reimbursement ("NPR") for fiscal year ending August 31, 2016 ("FY 2016"). The initial appeal contained the five (5) issues:

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

The estimated impacted of Issue 3 Medicaid eligible days for FY 2016 was $70,000 without a listing of specific days in dispute.

In July 2019, the Provider transferred Issues 2 and 5 to common issue related party ("CIRP") groups as the Provider is part of a health chain and is subject to the mandatory CIRP group

[1] The Medicare Contractor filed a Jurisdictional Challenge on September 18, 2019. The Provider filed a response on October 15, 2019. The Board dismissed Issue 1 on July 2, 2020.
[2] The Provider transferred this issue to Case No. 19-1409GC on July 19, 2019.
[3] The Provider withdrew this issue on September 10, 2019.
[4] The Provider transferred this issue to Case No. 19-1410GC on July 19, 2019

regulation at 42 C.F.R. § 405.1837(b)(1). On September 10, 2019, the Provider withdrew Issue 4. On July 2, 2020, the Board issued a decision dismissing Issue 1. As a result, the sole issue remaining in the appeal is Issue 3, the DSH Medicaid Eligible Days issue.

On July 31, 2019, CHS filed the cover page to its preliminary position paper. Similarly, on November 25, 2019, the Medicare Contractor filed its preliminary position paper.

On January 3, 2023, the Medicare Contractor filed a request that the Provider provide a listing of the additional Medicaid eligible days being pursued under Issue 3. The Provider did not file a response. Accordingly, on April 7, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3. Again, the Provider failed to reply even though a response was due within 30 days per Board Rule 44.3.

Medicare Contractor's Contentions

On May 23, 2022, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 4 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.

Provider's Request for Postponement

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

Board Decision:

According to its Appeal Request filed on December 6, 2018, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 3 as:

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

Statement of the Legal Basis

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

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

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

However, when CHS filed the December 6, 2018 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[6]

[5] Provider's Appeal Request (March 6, 2019).
[6] (Bold emphasis added.)

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[7] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> **Rule 25 Preliminary Position Papers**
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.

[7] (Bold emphasis added.)

****

25.2 Position Paper Exhibits

24.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to Board

Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

On August 7, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[8] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

[8] Provider's Preliminary Position Paper (July 31, 2019).

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $70,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[9]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[10] 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" [11] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on July 31, 2019 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[12] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. Due to Provider's failure to properly develop the merits of this issue in its position paper consistent 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2, not even a single day has been identified as being in dispute and, as such, the Board must assume there is $0 in actual dispute for this issue.

****

In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board hereby dismisses the Medicaid eligible days issue as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and

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[9] *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.

[10] 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.

[11] (Emphasis added.)

[12] Provider Preliminary Position Paper at 8.

filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the Medicare Contractor as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. Indeed, the record before the Board reflects no specific Medicaid eligible days in dispute ($0 in actual controversy) at this very late post-final position paper stage of the appeal. Further, the Board takes administrative notice that it has made similar dismissals in other cases in which CHS was the designated representative[13] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper and respond to the Motion to Dismiss.

As no issues remain pending, the Board hereby closes Case No. 19-0681 and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

[13] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Heart of Florida Regional Medical Center (Prov. No. 10-0137)
FYE 06/30/2016
Case No. 19-1318

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 19-1318 in response to a Motion to Dismiss and the Jurisdictional Challenge filed by the Medicare Contractor ("MAC"). The Board's is set forth below.

Background:

A. Procedural History for Case No. 19-1318

On February 4, 2019, Heart of Florida Regional Medical Center appealed a Notice of Program Reimbursement ("NPR") dated August 17, 2018, for its fiscal year ending June 30, 2016 ("FY 2016"). The initial appeal contained the following issues:

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

[1] The MAC filed a Jurisdictional Challenge regarding this issue on 1/2/2020.
[2] The Provider transferred this issue to Case No. 19-0173GC on 9/23/2019.
[3] The Provider transferred this issue to Case No. 19-0175GC on 9/23/2019.
[4] The Provider transferred this issue to Case No. 19-0198GC on 9/23/2019.
[5] The MAC filed a Motion to Dismiss regarding this issue on 4/6/2023.
[6] The Provider transferred this issue to Case No. 19-0159GC on 9/23/2019.

Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[7]

- Issue 8: Uncompensated Care ("UCC") Distribution Pool[8]
- Issue 9: 2 Midnight Census IPPS Payment Reduction[9]

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 September 23, 2019, the Provider transferred issues to various CIRP group appeals, including Issue 2, DSH/SSI Percentage (Systemic Issues) to Case No. 19-0173GC, CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group. After all transfers, only Issue 1 and Issue 5 remains in Case No. 19-1318.

On January 2, 2020, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue 1, DSH SSI Percentage (Provider Specific). The Provider did not file a response to the Jurisdictional Challenge.

On January 3, 2023, the MAC, WPS, filed a DSH Package Request regarding Medicaid Eligible days from the Provider, specifically requesting an electronic listing of the Medicaid eligible days at issue or if no documentation was available a response in accordance with Board Rules 7.3.1.2 and 25.2.2. The MAC requested a response by February 2, 2023; however, the Provider did not file any response. Accordingly, on April 6, 2023, the Medicare Contractor filed Motion to Dismiss regarding Issue 5-DSH Medicaid Eligible Days. Significantly, the Provider again failed to file a response to the MAC's Motion to Dismiss which was due within 30 days per Board Rule 44.3.

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

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

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

[7] The Provider transferred this issue to Case No. 19-0197GC on 9/23/2019.
[8] The Provider transferred this issue to Case No. 19-0177GC on 9/23/2019.
[9] The Provider transferred this issue to Case No. 19-0185GC on 9/23/2019.

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[10]

The Provider was also transferred into a mandatory group under Case No. 19-0173GC entitled "CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis:**
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. 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.[11]

The amount in controversy listed for the Provider as a participant in 19-0173GC is $8,137.

[10] Provider's Request for Hearing, Issue Statement (Feb. 5, 2019)
[11] Group Issue Statement, Case No. 19-0173GC.

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

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

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $8,137. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 19-0173GC.

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On January 2, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is

duplicative of Issue 2, which was transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[12]

Issue 5 – DSH Medicaid Eligible Days

On April 6, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 4 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[13]

Provider's Response

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

Board Analysis and Decision:

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

A. SSI Percentage (Provider Specific)

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

[12] MAC's Jurisdictional Challenge, at 3.
[13] MAC's Motion to Dismiss.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. Case 19-0173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[14] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[15] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[16] The DSH systemic issues filed into Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $8,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-0173GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 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.[17] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of 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

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

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.[18] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[19]

Accordingly, based on the record before it,[20] the Board must find that Issues 1 and the group issue in Group 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 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on February 5, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory

[18] (Last accessed Nov. 21, 2022.)
[19] (Emphasis added.)
[20] Again, the Provider failed to respond to the jurisdictional challenge and the Board must rule based on the record before it.

> instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[21]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

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

However, when the Provider filed the February 5, 2019 appeal request, it did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[22]

[21] Provider's Appeal Request (February 5, 2019).
[22] (Bold emphasis added.)

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[23] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> ****

[23] (Bold emphasis added.)

25.2 Position Paper Exhibits

24.2.1 General

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

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to Board

Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

- upon failure to appear for a scheduled hearing.

On October 2, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[24] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate

[24] Provider's Preliminary Position Paper (October 2, 2019).

> number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $9,023, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[25]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[26] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[27] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on October 2, 2019 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[28] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. Due to Provider's failure to properly develop the merits of this issue in its position paper consistent 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2, not even a single day has been identified as being in dispute and, as such, the Board must assume there is $0 in actual dispute for this issue.

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

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

The Board also dismisses Issue 5, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the MAC, 26 as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. In dismissing Issue 5, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative[29] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper and respond to the Motion to Dismiss.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

[29] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

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**
Bayfront Health Punta Gorda (10-0047)
FYE 09/30/2016
Case Number 19-1709

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documentation in Case No. 19-1709 in response to a Motion to Dismiss and the Jurisdictional Challenge filed by the Medicare Contractor ("MAC"). The Board's is set forth below.

Background:

A. Procedural History for Case No. 19-1709

On March 6, 2019, Bayfront Health Punta Gorda appealed a Notice of Program Reimbursement ("NPR") dated September 10, 2018, for its fiscal year ending September 30, 2016 ("FY 2016"). The initial appeal contained the following issues:

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

[1] The Medicare Contractor filed a Jurisdictional Challenge on March 17, 2020 and the Provider filed a response on April 8, 2020.
[2] The Provider transferred this issue to Case No. 19-0173GC on October 22, 2019.
[3] The Provider transferred this issue to Case No. 19-0175GC on October 22, 2019.
[4] The Provider transferred this issue to Case No. 19-0198GC on October 22, 2019.
[5] The Provider transferred this issue to Case No. 19-0159GC on October 22, 2019.

Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]

- Issue 8: Uncompensated Care ("UCC") Distribution Pool[7]
- Issue 9: 2 Midnight Census IPPS Payment Reduction[8]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2, 3, 4, 6, 7, 8, and 9 to groups for CHS. As a result of these transfers, the remaining issues in the appeal are Issue 1 and Issue 5. After all transfers, only Issue 1 and Issue 5 remains in Case No. 19-1709.

On March 17, 2020, the Medicare Contractor filed a Jurisdictional Challenge, regarding Issue 1, DSH SSI Percentage (Provider Specific). On April 8, 2020, the Provider timely filed a response to the Jurisdictional Challenge.

On January 4, 2023, the MAC, WPS, filed a DSH Package Request regarding Medicaid Eligible days from the Provider, specifically requesting an electronic listing of the Medicaid eligible days at issue or if no documentation was available a response in accordance with Board Rules 7.3.1.2 and 25.2.2. The MAC requested a response by February 3, 2023, however the Provider did not respond. Accordingly, on April 7, 2023, the Medicare Contractor filed Motion to Dismiss, regarding Issue 5-DSH Medicaid Eligible Days. The Provider did ***not*** file a response to the MAC's Motion to Dismiss even though a response was due within 30 days per Board Rule 44.3.

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

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

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

[6] The Provider transferred this issue to Case No. 19-0197GC on October 22, 2019.
[7] The Provider transferred this issue to Case No. 19-0177GC on October 22, 2019.
[8] The Provider transferred this issue to Case No. 19-0185GC on October 22, 2019.

> 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 was also transferred into a mandatory group under Case No. 19-0173GC entitled "CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group." This CIRP group has the following issue statement:

> **Statement of the Issue:**
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/con-covered/eligible SSI days?
>
> **Statement of the Legal Basis:**
> The Provider(s) contend(s) that the MAC's determination for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records,
> 2. 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.[10]

[9] Provider's Request for Hearing, Issue Statement (Mar. 6, 2019)
[10] Group Issue Statement, Case No. 19-0173GC.

The amount in controversy listed for the Provider as a participant in 19-0173GC is $28,000.

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

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include 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 percentages 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 faction.

The only exhibit included with the preliminary position paper that relates to Issue 1 was Exhibit 1, which was listed as an Eligibility Listing, but noted that it would be sent under separate cover. Exhibit 2 shows the amount in controversy as $27,950. This is the same amount that is listed as the amount in controversy for this Provider as a participant in 19-0173GC.[11]

Medicare Contractor's Contentions

[11] The amount in controversy listed in the appeal and Request to Transfer lists the amount in controversy as $28,000.

Issue 1 – DSH SSI Percentage (Provider Specific)

On March 17, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of Issue 2, which was transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[12]

Issue 5 – DSH Medicaid Eligible Days

On April 7, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that both the Provider's Preliminary and Final Position Papers stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 4 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[13]

Provider's Response

The Provider filed a response to the Jurisdictional Challenge on April 8, 2020. The Provider contends Issue 1 and Issue 2 represent different components of the SSI Issue and request the Board to find jurisdiction over the DSH/SSI provider specific issue. The Provider cites to Board Rule 8.1, which states, "some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…"[14]

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

Board Analysis and Decision:

[12] MAC's Jurisdictional Challenge, at 3.
[13] MAC's Motion to Dismiss.
[14] Provider Response to MAC's Jurisdictional Challenge on April 8, 2020.

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was directly filed into Case No. Case 19-0173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[15] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17] The DSH systemic issues filed into Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i). Indeed, the Provider has the same amount in controversy for both Issue 1 and for its participation in the CIRP group, namely $28,000.

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-0173GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

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[15] Individual Appeal Request, Issue 1.
[16] *Id.*
[17] *Id.*

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 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.[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) in its appeal request of 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.[19] It is insufficient to simply respond to the jurisdictional challenge by saying the Provider "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio" without explaining what that belief is based on and not provide examples to differentiate this issue from the SSI Systemic issue which is common to all CHS providers.

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;

[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] In its response 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 errors that have been previously identified in the Baystate litigation." Yet in the very next sentence, the Provider says the opposite: "*Once patients are identified*, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage." (Emphasis added.) Due to the immediate contradiction and the fact that no examples have been provided, the Board must assume no such examples have actually been identified.

> 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:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of 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 self-service process* enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[21]

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

Accordingly, based on the record before it, Board must find that Issues 1 and the group issue in Group 19-0173GC are the same issue. Moreover, the Provider has failed to properly develop the merits of Issue 1 in compliance with Board Rule 25.2.2 and 42 C.F.R. § 405.1853(b)(2) because the Provider's preliminary position paper did not set forth the relevant facts and arguments regarding the merits of this Provider's claims with regards to the DSH SSI Percentage data errors aspect of Issue 1. The Board also finds that the Provider has abandoned the DSH SSI Percentage data errors issue by filing a perfunctory position paper that did not include any discussion or analysis of the MedPAR data files that are available to providers. Based on these multiple and independent bases the Board dismisses the first aspect of Issue 1 from the appeal.

2. Second Aspect of Issue 1

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on March 6, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 5 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, 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's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

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

However, when CHS filed the March 6, 2019 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

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

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for

[22] Provider's Appeal Request (March 6, 2019).
[23] (Bold emphasis added.)

the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[24] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*
>
> **25.1 Content of Position Paper Narrative**
>
> The text of the position papers must include the elements addressed in the following sub-sections.
>
> **25.1.1 Provider's Position Paper**
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.
>
> ****
>
> **25.2 Position Paper Exhibits**
>
> **25.2.1 General**

[24] (Bold emphasis added.)

> With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
>
> Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

On October 29, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[25] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days,

[25] Provider's Preliminary Position Paper (October 29, 2019).

> as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $94,661, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[26]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[27] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[28] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on October 29, 2019 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[29] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. As such, the Board finds that the issue has been effectively abandoned since not even a single day has been identified as being in dispute, thereby rendering the actual amount in controversy as $0.

****

[26] *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.
[27] 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.
[28] (Emphasis added.)
[29] Provider Preliminary Position Paper at 8.

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

Similarly, the Board dismisses Issue 5, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. The Provider has also failed to provide any timely explanation to the MAC, as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. In dismissing Issue 5, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative[30] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or respond to the Motion to Dismiss.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

[30] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Davis Regional Medical Center (Prov. No. 34-0144)
FYE 09/30/2016
Case No. 19-1850

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Contractor's Motion to Dismiss. The Board's analysis and determination is set forth below.

Pertinent Facts:

Davis Regional Medical Center submitted a request for hearing on March 25, 2019, from a Notice of Program Reimbursement ("NPR") dated September 24, 2018. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage
- Issue 3: DSH-SSI Fraction/Medicare Managed Care Part C Days
- Issue 4: DSH-SSI Fraction/Dual Eligible Days
- Issue 5: DSH-Medicaid Eligible Days
- Issue 6: DSH-Medicaid Fraction/Medicare Managed Care Part C Days
- Issue 7: DSH-Medicaid Fraction/Dual Eligible Days
- Issue 8: Uncompensated Care ("UCC") Distribution Pool
- Issue 9: 2 Midnight Census IPPS Payment Reduction

As the Provider is commonly owned by Community Health Systems ("CHS"), on October 22, 2019, the Provider transferred Issues 2, 3, 4, 5, 6, 7. 8 and 9 to various common issue related party ("CIRP) group appeals. By letter dated May 26, 2020, the Board dismissed Issue 1. As a result, the sole remaining issue in this appeal is Issue 5, DSH Medicaid eligible days.

On November 12, 2019, the Provider filed its Preliminary Position Paper. Similarly, on March 17, 2020, the MAC filed its Preliminary Position Paper.

On January 4, 2023, the MAC filed its 3rd and Final Request for DSH Package as it relates to Issue 3. The Provider did not file a response. Accordingly, on June 21, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3. The Provider did not file a response and the period allotted under Board Rule 44.3 was 30 days.

Medicare Contractor's Motion to Dismiss

On June 21, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines Board's Rules 7, 25.2.1, and 25.2.2 which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 413.24(c) and §412.106(b)(4)(iii) which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Position Paper affirmative stated that an eligibility listing would be sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in over 4 years since the appeal was filed. The MAC states it contacted the Provider on several occasions: August 9, 2021 and November 2021. Each time the Provider has not responded with an updated list of additional eligible days. On January 4, 2023, the MAC submitted its third and final request for DSH package via OH CDMS and requested a response by February 3, 2023. No response was received.

Provider's Response to Motion to Dismiss

To date, the Provider has not filed a response to the Medicare Contractor's Motion to Dismiss, and the time for doing so has lapsed per Board Rule 44.3.

Board Decision:

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

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

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

> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, 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.[1]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

On November 12, 2019, the Provider filed its preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[2] Indeed, the position paper did not even identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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

[1] Provider's Appeal Request (March 26, 2019).
[2] Provider's Preliminary Position Paper (November 12, 2019).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $59,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. The Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[3]

Rule 25 Preliminary Position Papers

> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*

[3] *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.

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

24.2.1 General

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

25.2.2 Unavailable and Omitted Documents

If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.

> Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
>
> Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

> **COMMENTARY:**
>
> The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions.*
>
> CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

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

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

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

The Board 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"[4] and, pursuant to o 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25, the Provider has the burden to identify the number of days in dispute and present the supporting evidence (proving each day) as part of its position paper filing unless it adequately explains therein why such evidence is unavailable in compliance with Board Rule 25.2.2 (as issued by the Board pursuant to its authority under 42 C.F.R. §§ 405.1853(b)(3) and 405.1868(a)). In this regard, the Board notes that the Provider represented in its preliminary position paper filed on November 12, 2019 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[5] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready.

The Board finds that the Provider has failed to provide a Medicaid eligible day listing or other supporting documentation for the Medicaid Eligible days issue as required by the controlling regulations at 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25 (as applicable via Board Rule 27.2). Nor has the Provider provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. Indeed, the Board takes administrative notice that it has

[4] (Emphasis added.)
[5] Provider Preliminary Position Paper at 11.

made similar dismissal in other cases in which CHS was the designated representative[6] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper and failed to respond to the Motion to Dismiss. Accordingly, the Board must conclude that there are no days at issue and that the amount in controversy is $0.

As such, the Board hereby dismisses the DSH Medicaid Eligible Days issue from the appeal. As this was the last remaining issue in the appeal, the Board closes Case No. 19-1850 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

[6] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Decision - Dismissal***
Tennova Healthcare – Volunteer Martin (Provider No. 44-0061)
FYE 01/31/2017
Case No. 20-0434

Dear Mr. Summar:

The Provider Reimbursement Review Board ("Board") reviewed the documentation in Case No. 20-0434 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background:

A. *Procedural History for Case No. 20-0434*

On May 15, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end January 31, 2017.

On November 8, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

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

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Community Health groups on June 18, 2020. As a result, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 18, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] This issue was withdrawn on May 4, 2021.
[3] On June 18, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

On June 29, 2020, the Provider filed its preliminary position paper.

On October 22, 2020, the Medicare Contractor filed its preliminary position paper.

On December 8, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. The Provider failed to respond within the 30-day period allotted under Board Rule 44.4.3:

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

On January 4, 2023, the Medicare Contractor filed a Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days (*i.e.*, by February 3, 2023). On June 21, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response.

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

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

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[4]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 20-0997GC, CHS CY 2017 DSH SSI Percentage CIRP Group, on June 18, 2020. The Group Issue Statement in Case No. 20-0997GC reads, in part:

> **Statement of the Issue:**

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

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $6,000.

On June 29, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (January 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] Group Issue Statement, Case No. 20-0997GC.

> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

MAC's Contentions

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

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

---

[6] Provider's Preliminary Position Paper at 8-9 (June 29, 2020).
[7] Jurisdictional Challenge at 6-7 (Dec. 8, 2020).
[8] *Id*. at 4-6.

Issue 3 – DSH Payment – Medicaid Eligible Days

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

a. That the Provider has failed to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.
d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days.
e. That the Provider's claim for additional Medicaid Eligible Days is therefore dismissed.[9]

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

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (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.

[9] Motion to Dismiss at 6 (June 21, 2023).
[10] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

A. DSH – SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board is dismissing both aspects of Issue 1.

1. First Aspect of Issue 1

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

The DSH – SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[11] 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)."[12] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13]

The Provider's DSH – SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH – 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[14], the Board dismisses this aspect of the DSH – SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 20-0997GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case

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

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. 20-0997GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-0997GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." For example, the Provider asserts that it "has learned that . . . the SSI entitlement of individuals can be ascertained from State records" but fails to explain what that means, what the basis for the alleged fact is,[16] or why that is 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

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[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 example of how SSI entitlement can be ascertained from state records.

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 20-0997GC are the same issue.[20] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH – SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

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

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the

[17] Last accessed February 24, 2023.
[18] Emphasis added.
[19] Again, the Board notes that the Provider failed to reply to the jurisdictional challenge and the Board must base its ruling on the record before it.
[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

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.[21]

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

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

Board Rule 7.2 (B) states:

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

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

> payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2 (B).

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[23]

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and *the merits of the provider's Medicare payment claims for each remaining issue*.
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[24]

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

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

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

Similarly, with regard to position papers,[25] Board Rule 25.2 (A) requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2 (B) provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the opposing party.[27]

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

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

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

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

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

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

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

On June 29, 2020, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[28] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does

[28] Provider's Preliminary Position Paper (October 2, 2019).

> not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $27,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover even after the MAC submitted a follow up request for the listing on January 4, 2023. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[29]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25 Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[30] 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"[31] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on June 29, 2020 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[32] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. Due to Provider's failure to properly develop the merits of this issue in its position paper consistent 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2, not even a single day has been identified as being in dispute and, as such, the Board must assume there is $0 in actual dispute for this issue.

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[29] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[30] 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.
[31] (Emphasis added.)
[32] Provider Preliminary Position Paper at 8.

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

****

In summary, the Board hereby dismisses the DSH Payment – SSI Percentage (Provider Specific) issue from appeal as it is duplicative of the common issue in the CIRP group under Case No. 20-0997GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

The Board also dismisses issue #3 DSH Payment – Medicaid Eligible Days as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Nor has the Provider provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding numerous follow up requests for the documentation and a follow-up Motion to Dismiss for failure to reply.

Further, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or after numerous requests.[33]

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/18/2023

X Clayton J. Nix

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

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

[33] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Dismissal of SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues***
College Station Medical Center (Prov. No. 45-0299)
FYE 09/30/2015
Case No. 19-0650

Dear Mr. Summar and Mr. Lamprecht,

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

Background:

A. *Procedural History for Case No. 19-0650*

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

On November 29, 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
4. Uncompensated Care ("UCC") Distribution Pool[2]
5. 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is owned by CHS Systems, Inc. ("CHS") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4, and 5 to CHS groups on June 14, 2019. As a result, the remaining issues in this appeal are Issues 1 and 3.

[1] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0554GC.
[3] On June 14, 2019, this issue was transferred to PRRB Case No. 18-0555GC.

On April 4, 2019, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. On May 1, 2019, CHS as the Provider's representative, filed a response to the challenge.

On July 23, 2019, the Provider filed its preliminary position paper and, similarly on November 15, 2019, the Medicare Contractor filed its preliminary position paper.

On January 6, 2023, the Medicare Contractor filed a Final Request for the Medicaid Eligible Days Listing in connection with Issue 3 and requested a response within 30 days. CHS did not file any response to that request.

Accordingly, on July 4, 2023, the Medicare Contractor filed its Motion to Dismiss Issue 3 as the Provider failed to file any response. Again, CHS failed to file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

B. 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.[4]

As the Provider is commonly owned by CHS, the Provider transferred its Issue 2 – DSH – SSI Percentage to the CIRP group under 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group, on June 14, 2019. The Group Issue Statement in Case No. 18-0552GC 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

[4] Issue Statement at 1 (Nov. 29, 2018).

upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

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

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

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

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

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $23,000.

On July 23, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include

[5] Group Issue Statement, Case No. 18-0552GC.

> all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Texas and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Texas and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *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.[6]

C. Filings Concerning the Jurisdictional Challenge and Motion to Dismiss

1. MAC's Contentions

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

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

[6] Provider's Preliminary Position Paper at 8-9 (July 23, 2019).

> 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 recent jurisdictional decisions.[7]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[8]

Issue 3 – DSH Payment – Medicaid Eligible Days

In its July 4, 2023 Motion to Dismiss, the MAC argued that the Provider abandoned Issue 3, 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 July 23, 2019 preliminary position paper in violation of Board Rule 25.3. The MAC notes that it specifically requested this listing from the Provider on 3 different dates: January 17, 2019; May 13, 2022; and January 6, 2023. However, the Provider never responded to those requests. The MAC then requested the Board make the following findings and Order the following:

> a. That the Provider has failed to furnish documentation in supports of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.
> b. That the Provider has made affirmative statements in its Preliminary Position Paper that it was submitting such supporting documentation to the MAC.
> c. That the Provider's failure to furnish such documentation (or describe why such documentation is unavailable is in violation of PRRB Rules 7, 27.2, 25.2.1 and 25.2.2.[9]
> d. That the Provider has effectively abandoned its claim for additional Medicaid Eligible Days. . .[10]

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)

---

[7] Jurisdictional Challenge at 6 (Apr. 4, 2019).
[8] *Id*. at 5.
[9] PRRB Rules v. 2.0 (Aug. 2018).
[10] Motion to Dismiss at 5 (May 16, 2023).

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."[11] 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."[12]

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."[13]

Issue 3 – DSH Payment – Medicaid Eligible Days

The Board Rules require that responses to the opposing party motions must be filed within thirty (30) days of the filing of the original motion was sent to the Board and opposing party.[14] ***The Provider has not filed a response to the Motion to Dismiss and the time for doing so has elapsed.*** Board Rule 44.3 specifies: "Unless the Board imposes a different deadline, an opposing party may file a response, with relevant supporting documentation, within 30 days from the data that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

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

A. DSH Payment/SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

[11] Jurisdictional Response at 1 (May 1, 2019).
[12] *Id*. at 2.
[13] *Id*.
[14] Board Rule 44.3, v. 3.1 (Nov. 2021).

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. 18-0552GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 18-0552GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[15] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[16] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[17] The DSH systemic issues filed into Case No. 18-0552GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-0552GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 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 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) in its appeal request of 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.[19] It is insufficient to simply respond to the jurisdictional challenge by

[15] Individual Appeal Request, Issue 1.
[16] *Id.*
[17] *Id.*
[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] In its response 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 errors that have been previously identified in the Baystate litigation." Yet in the very next sentence, the Provider says the opposite: "*Once patients are identified*, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage."

saying the Provider "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio" without explaining what that belief is based on and not provide examples to differentiate this issue from the SSI Systemic issue which is common to all CHS providers.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, the argument on this issue was only a mere 4 sentences without any exhibits. More specifically, it was perfunctory and 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.

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

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

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***

(Emphasis added.) Due to the immediate contradiction and the fact that no examples have been provided, the Board must assume no such examples have actually been identified.

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 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*, 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. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH 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 Payment – Medicaid Eligible Days

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

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

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

> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[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 7.3.2 states:

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

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]

---

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

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).

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 opposing party.[28]

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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).

[28] (Emphasis added).

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

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

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

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

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

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

As stated by the MAC and uncontested by the Provider, when the Provider filed their preliminary position paper it indicated that it would be sending the eligibility listing under separate cover. The position paper did not identify how many Medicaid eligible days remained in dispute in this case. While the Calculation Support filed with their appeal notes a net impact of $67,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover even after the MAC submitted a follow up request for the listing on January 4, 2023 in OH CDMS and failing to respond to numerous requests. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting

documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[29]

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

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"[31] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[32]

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 and 42 C.F.R. §§ 412.106(b)(iii) and 405.1853(b)(2)-(3) related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do. The Board takes administrative notice that it has made similar dismissal in other cases involving CHS providers.[33] Notwithstanding, CHS failed to include the Medicaid eligible days listing with its preliminary position paper or even file a copy following the MAC's Motion to Dismiss.

****

[29] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[30] (Emphasis added).
[31] (Emphasis added).
[32] 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.
[33] Ba

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. 18-0552GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue and the Provider failed to meet the Board requirements for position papers.

Similarly, the Board dismisses Issue 3, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. Further, the Provider has failed to provide any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding a second request for the documentation and a follow-up Motion to Dismiss for failure to reply. In dismissing Issue 3, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative[34] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or respond to the Motion to Dismiss.

As no issues remain pending, the Board hereby closes Case No. 19-0650 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:

8/21/2023

X Clayton J. Nix

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

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

[34] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Alliance Health Midwest (Prov. No. 37-0094)
FYE 06/30/2016
Case No. 19-1695

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Contractor's Motion to Dismiss. Additionally, the Board has reviewed Issue 1- Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific on its own motion. The Board's analysis and determination is set forth below.

Background

A. Procedural History for Case No. 19-1695

On February 24, 2019, the Provider submitted a request for hearing from a Notice of Program Reimbursement ("NPR") dated August 24, 2018. The request included the following issues:

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

[1] The Provider transferred this issue to Case No. 19-0173GC on September 24, 2019.
[2] The Provider transferred this issue to Case No. 19-0175GC on September 24, 2019.
[3] The Provider transferred this issue to Case No. 19-0198GC on September 24, 2019
[4] The Provider transferred this issue to Case No. 19-0159GC on September 24, 2019.
[5] The Provider transferred this issue to Case No. 19-0197GC on September 24, 2019.

- Issue 8: Uncompensated Care ("UCC") Distribution Pool[6]
- Issue 9: 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2, 3, 4, 6, 7, 8, and 9 to groups for CHS. As a result of these transfers, the remaining issues in the appeal are Issue 1 and Issue 5.

On October 15, 2019, the Provider filed its Preliminary Position Paper and, similarly, on February 19, 2020, the MAC filed its Preliminary Position Paper.

On January 3, 2023, the MAC, WPS, formally requested a DSH package from the Provider on Issue 5 (a listing of the additional Medicaid eligible days being claims plus supporting documentation) or if no documentation was available a response in accordance with Board Rules 7.3.1.2 and 25.2.2. The MAC requested a response by February 2, 2023 however no response was received from the Provider.

Accordingly, on April 6, 2023, the MAC filed a Motion to Dismiss Issue 5. However, the Provider again failed to file any response which was due within 30 days per Board Rule 44.3.

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

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of how the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[8]

[6] The Provider transferred this issue to Case No. 19-0177GC on September 24, 2019.
[7] The Provider transferred this issue to Case No. 19-0185GC on September 24, 2019.
[8] Provider's Request for Hearing, Issue Statement (Feb. 25, 2019)

The Provider was also transferred into a mandatory group under Case No. 19-0173GC entitled "*CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the number of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis:**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report 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.[9]

On October 15, 2019, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all

[9] See Group Issue Statement, PRRB Case no. 19-0173GC

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

Medicare Contractor's Contentions

On April 6, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Paper stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 3 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.

Additionally, the MAC stated that it was going to file a jurisdictional challenge over issue 1, however that challenge has not been filed as of the date of this decision.[10]

Provider's Response

The Provider did not file a response to the Motion to Dismiss. Board Rule 44.4.3 specifies, "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional

[10] MAC's Motion to Dismiss.

challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

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

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 19-0173GC, *CHS CY 2016 HMA DSH SSI Percentage (Systemic Errors) CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 19-0173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[11] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[12] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[13] The DSH systemic issues filed into Case No. 19-0173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-0173GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by

[11] Individual Appeal Request, Issue 1.
[12] *Id.*
[13] *Id.*

Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 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.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of 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, the argument pertaining to this issue was 4 sentences long without any supporting exhibits. More specifically, it was perfunctory and did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-0173GC. For example, it alleges that "SSI entitlement of individuals can be ascertained from State records" but fails to explain how it can, explain how that information is relevant, and whether such a review was done for purposes of the year in question. 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.

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

> 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.[15] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Accordingly, based on the information before it,[17] Board must find that Issues 1 and the group issue in Group 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 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost

[15] (Last accessed Nov. 21, 2022.)
[16] (Emphasis added.)
[17] Per 42 C.F.R. 405.1853(b)(2) and Board Rule 25, the position paper is to fully explain the merits of the Provider's position on the issue but here the Provider failed to do so and instead filed a perfunctory position paper where the argument for this issue was a mere 4 sentences long without any exhibits.

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on February 25, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 5 as:

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

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

[18] Provider's Appeal Request (Feb. 25, 2019).

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

However, when Community Health Systems ("CHS") filed the February 25, 2019 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[19]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[20] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers

[19] (Bold emphasis added.)
[20] (Bold emphasis added.)

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

24.2.1 General

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

versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

25.2.3 List of Exhibits

Parties must attach a list of the exhibits exchanged with the position paper.

25.3 Filing Requirements to Board

Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

On October 15, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[21] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.

[21] Provider's Preliminary Position Paper (October 15, 2019).

> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).
>
> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $79,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments

and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[22]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[23] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[24] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on October 15, 2019 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[25] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. As such, the Board finds that the issue has been effectively abandoned since not even a single day has been identified as being in dispute, thereby rendering the actual amount in controversy as $0.

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-0173GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

Similarly, the Board dismisses Issue 5, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. The Provider also failed to provide any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. I n dismissing Issue 5, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated

[22] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[23] 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.
[24] (Emphasis added.)
[25] Provider Preliminary Position Paper at 8.

representative[26] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or respond to the Motion to Dismiss.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/21/2023

X Clayton J. Nix

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

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

[26] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Woodland Heights Medical Center (Prov. No. 45-0484)
FYE 12/31/2015
Case No. 19-1844

Dear Mr. Summar,

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

Background

A. Procedural History for Case No. 19-1844

Woodland Heights Medical Center submitted a request for hearing on March 26, 2019 from a Notice of Program Reimbursement ("NPR") dated September 24, 2018. The hearing request included the following issues:

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

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), the Provider transferred Issue 2, 4, and 5 to groups for CHS. As a result of these transfers, the remaining issues in the appeal are Issue 1 and Issue 3.

[1] The MAC filed Jurisdictional Challenge on January 29, 2020.
[2] The Provider transferred this issue to Case No. 18-0552GC on October 22, 2019.
[3] The Provider transferred this issue to Case No. 18-0555GC on October 22, 2019.
[4] The Provider transferred this issue to Case No. 18-0554GC on October 22, 2019.

On November 12, 2019, the Provider filed its preliminary position paper.

On January 29, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. On February 27, 2020, the Provider filed a response to the Medicare Contractor's Jurisdictional Challenge for Issue 1.

On March 12, 2020, the Medicare Contractor filed its preliminary position paper.

On April, 29, 2021, the Medicare Contractor filed its first request that the Provider furnish within 45 days a listing of additional Medicaid eligible days being claimed with supporting documentation. The Provider's representative, Community Health Systems ("CHS"), did not file a response.

On July 14, 2021, the Medicare Contractor filed its second request that the Provider furnish within 45 days a listing of additional Medicaid eligible days being claimed with supporting documentation. Again, CHS did not file a response.

On January 4, 2023, the Medicare Contractor filed its "3rd and Final" request that the Provider furnish by February 3, 2023 a listing of additional Medicaid eligible days being claimed with supporting documentation. Again, CHS did not file a response.

Accordingly, on June 21, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3- DSH Medicaid Eligible Days. Once again, CHS failed to file any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3, was due within 30 days.

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

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

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

> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[5]

As discussed above, the Provider was also transferred into a mandatory group under Case No. 18-0552GC entitled "*QRS CHS CY 2015 DSH SSI Percentage CIRP Group*." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculation accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statue at 42 U.S.C §1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis:**
>
> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi). The Provider contends that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records;
> 2. Failure to adhere to required notice and comment rulemaking

[5] Provider's Request for Hearing, Issue Statement (March 26, 2019)

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 November 12, 2019, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> **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 Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to L*oma Linda Community Hospital v. Dept of Health and Human Services*, No. CVT94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFAIOIS, 09-07-009, which was published in the Federal Register on August 18, 2000. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

[6] See Group Issue Statement, PRRB Case no. 18-0552GC

On January 29, 2020, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of an issue which was transferred into Group Case No. 18-0552GC, *QRS CHS CY 2015 DSH SSI Percentage CIRP Group*. The Portion of Issue 1 concerning realignment should be dismissed because there was no final determination over SSI realignment and the Provider's appeal is premature as the Provider has not exhausted all available remedies.[7]

Issue 2 – DSH Medicaid Eligible Days

On June 21, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable. The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation. Finally, the Motion notes that the Provider's Preliminary Paper stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 4 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[8]

Provider's Response

The Provider filed a response to the Jurisdictional Challenge on May 18, 2020. The Provider contends Issue 1 represent different and separate components of the SSI Issue and request the Board to find jurisdiction over the DSH/SSI provider specific issue. The Provider cites to Board Rule 8.1, which states, "some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…"[9]

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

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in

[7] MAC's Jurisdictional Challenge, at 3.
[8] MAC's Motion to Dismiss.
[9] Provider Response to MAC's Jurisdictional Challenge on February 27, 2020.

controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A. SSI Percentage (Provider Specific)

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

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 18-0552GC, *QRS CHS CY 2015 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the DSH/SSI (Systemic Errors) issue that was directly filed into Case No. 18-0552GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] The DSH systemic issues filed into Case No. 18-0552GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 18-0552GC, for this same provider and fiscal year. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-0552GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in

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

Baystate, may impact the SSI percentage for each provider differently.[13] 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) in its appeal request of 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.[14] It is insufficient to simply respond to the jurisdictional challenge by saying the Provider "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio" without explaining what that belief is based on and not provide examples to differentiate this issue from the SSI Systemic issue which is common to all CHS providers.

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.

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.

---

[13] 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).

[14] In its response 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 errors that have been previously identified in the Baystate litigation." Yet in the very next sentence, the Provider says the opposite: "*Once patients are identified*, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage." (Emphasis added.) Due to the immediate contradiction and the fact that no examples have been provided, the Board must assume no such examples have actually been identified.

> 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.[15] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Accordingly, based on the record before it, the Board must find that Issues 1 and the group issue in Group 19-1409GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost

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

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

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on March 26, 2019, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[17]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and desire to be included in their Medicaid percentage and DSH computations, with their appeal request.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether

[17] Provider's Appeal Request (March 26, 2019).

> the adjustment is correct, describe why the underlying information is unavailable.

However, when Community Health Systems ("CHS") filed the March 26, 2019 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (2) The Board has the discretion to extend the deadline for submitting a position paper. **Each position paper must set forth the relevant facts and arguments regarding** the Board's jurisdiction over each remaining matter at issue in the appeal (as described in § 405.1840 of this subpart), and **the merits of the provider's Medicare payment claims for each remaining issue.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[18]

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

The Board has issues Rules to implement c. Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[19] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers

[18] (Bold emphasis added.)
[19] (Bold emphasis added.)

COMMENTARY:

Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

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

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

24.2.1 General

With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for

> resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.
>
> **25.2.2 Unavailable and Omitted Documents**
>
> Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
>
> Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

COMMENTARY:

The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.

CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned
- upon failure of the provider or group to comply with Board procedures,

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On November 12, 2019, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[20] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

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

[20] Provider's Preliminary Position Paper (November 12, 2019).

> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2015 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $26,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[21]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[22] 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"[23] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on November 12, 2019 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[24] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready and notwithstanding the 3 separate

---

[21] *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.

[22] 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.

[23] (Emphasis added.)

[24] Provider Preliminary Position Paper at 8.

requests and Motion to Dismiss for that listing that the Medicare Contractor filed in this case. As such, the Board finds that the issue has been effectively abandoned since not even a single day has been identified as being in dispute, thereby rendering the actual amount in controversy as $0.

****

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, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

Similarly, the Board dismisses Issue 3, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and filing supporting exhibits as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)- (3) and Board Rules 27.2 and 25. The Provider has also failed to provide any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case. In dismissing Issue 3, the Board takes administrative notice that it has made similar dismissal in other cases in which CHS was the designated representative[25] and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper or respond to the 3 requests for the listing and the Motion to Dismiss.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/21/2023

X Clayton J. Nix

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

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

[25] Examples of CHS individual provider cases which the Board dismissed for failure of the Provider to provide a listing of Medicaid eligible days include, but are not limited to: Case No. 22-0676 (dismissed by Board letter dated December 7, 2022 based on a MAC July 13, 2022 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper); Case No. 21-0317 (dismissed by Board letter dated April 3, 2023 based on a October 12,2021 final position paper request citing the Provider's failure to file the Medicaid eligible days listing with the preliminary position paper or under separate cover; and Case No. 18-0283 (dismissed by Board letter dated March 28, 2023 based on a MAC January 9, 2023 request for dismissal of the Medicaid eligible days issue for failure to file Medicaid eligible days listing with the preliminary position paper).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Duplicative Filings involving Westerly Hospital & Yale-New Haven***
Westerly Hospital, Provider No. 41-0013, FYE 9/30/2019
Appeal Filed 6/6/2023 Case No. 23-1425
Appeal Filed 6/16/2023 Case No. 23-1446

And, as a participant in:
Case No. 19-0463GC – Yale-New Haven FFY 2019 IPPS Understated Standard. Pymt. Amt. CIRP
Case No. 22-1272GC – Yale-New Haven CY 2019 IPPS Understated Standard. Pymt. Amt. CIRP

Dear Mr. Ravindran and Mr. Roth:

The Provider Reimbursement Review Board (the Board) has reviewed the referenced individual appeals and common issue related party ("CIRP") group appeals, which appear to be duplicative. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On **December 5, 2018**, Quality Reimbursement Services, Inc. ("QRS") filed a group appeal request to establish the CIRP group under **Case No. 19-0463GC** entitled the "Yale-New Haven FFY 2019 IPPS Understated Standardized Payment Amount CIRP Group." The group was filed from the August 17, 2018 Notice in the Federal Register and includes the following five providers which were all ***directly*** added to the group:

- Lawrence + Memorial Hospital (Prov. No. 07-0007; FYE 9/30/2019)
- Bridgeport Hospital (Prov. No. 07-0010; FYE 9/30/2019)
- Greenwich Hospital Association (Prov. No. 07-0018; FYE 9/30/2019)
- Yale New Haven Hospital (Prov. No. 07-0022, FYE 9/30/2019)
- Westerly Hospital (Prov. No. 41-0013; FYE 9/30/2019)

Significantly, each of the participant's has a fiscal year end that coincides with the federal fiscal year. In filing the appeal request for Case No. 19-0463GC, QRS certified that "the group issued filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal." Finally, on December 3, 2019 (roughly a year after the appeal was filed), QRS designated the group fully formed.

On **August 11, 2022**, QRS filed a *second* group request to establish the CIRP group under **Case No. 22-1272GC** entitled the "Yale-New Haven CY 2019 IPPS Understated Standardized Payment Amount CIRP Group." The second CIRP group, which is not yet fully formed, includes three of the five providers in Case No. 19-0463GC, but the Providers in this group were directly added to the group from receipt of their respective Notices of Program Reimbursement ("NPRs"):

- Lawrence + Memorial Hospital (Prov. No. 07-0007; FYE 9/30/2019)
- Bridgeport Hospital (Prov. No. 07-0010; FYE 9/30/2019)
- Greenwich Hospital Association (Prov. No. 07-0018; FYE 9/30/2019)

Significantly, the fiscal year end for each of these participants coincides with the federal fiscal year. QRS ***falsely*** certified that "the group issued filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal."

On **June 6, 2023**, QRS filed an individual appeal for Westerly Hospital ("Westerly") for its FYE 9/30/2019 under **Case No. 23-1425**. QRS indicated that the Provider's parent organization is Yale New Haven Health System.[1] The letter appointing QRS as the representative for Westerly Hospital was limited ***solely*** to one issue, namely the standardized payment amount issue. Westerly's appeal, which was filed from receipt of its December 20, 2022 NPR, includes a single issue: Standardized Payment Amount (*which is the issue under appeal in Case No. 19-0463GC and 22-1272GC*). In filing this appeal, QRS ***falsely*** certified that "none of the issues filed in this appeal are pending in any other appeal for the same period and provider, nor have they been adjudicated, withdrawn, or dismissed from any other PRRB appeal."

On **June 16, 2023**, Hooper, Lundy & Bookman, P.C. ("Hooper Lundy") filed an individual appeal for Westerly for its FYE 9/30/2019 under **Case No. 23-1446**.[2] This appeal was also filed from the December 20, 2022 NPR and includes a different issue: FY 2019 Impact of Denial of MDH Classification. Similarly, the letter appointing Hooper Lundy was limited to the MDH classification issue.

Board Determination:

At the outset, the Board notes that there are two matters for Westerly and the Yale-New Haven organization that must be addressed. First, it is not disputed that Westerly is under the Yale New

[1] The Appointment of Designated Representative Letter for Case No. 23-1425 was signed on May 23, 2023 by Jackie Wrinn, Associate Director of Corporate Business Services at Yale New Haven Health. The authorization was specific to the handling of the Standardized Payment Amount issue.

[2] The Designation of Provider Representative letter for Case No. 23-1446 was signed on June 16, 2023 and was also signed by Jackie Wrinn of Yale New Haven Health. The authorization was specific to the denial of the Hospital's request for classification as a Medicare Dependent Hospital ("MDH"). It should be noted that the Representation Letter states, "The Hospital's challenge to the MAC's November 22, 2019 denial currently is pending before the Board in PRRB Case No. 20-1696, with Hooper, Lundy & Bookman, P.C. serving as Representative." Upon review, however, Case No. 20-1696 is for the Provider's FY 12/31/2018.

Haven parent organization and, as such, it is required to pursue any common issue, if there are other related Providers pursuing the same issue, in a CIRP group.[3]

42 C.F.R. §405.1837(b) and Board Rule 12.3.1, both advise that "[p]roviders under common ownership or control that wish to appeal a specific matter that is common to the providers must bring the appeal as a group appeal." Thus, for purposes of the Yale New Haven organization and its pursuit of the IPPS Understated Standardized Payment Amount issue, it is the Board's policy to establish ***only*** one (1) CIRP group appeal per year.[4] In violation of this requirement, QRS established two different CIRP groups under Case Nos. 19-0463GC and 23-1425GC, appealing the same issue for the same period. Here, the participants fiscal year coincides with the federal fiscal year and, as such, it is clear that there is a perfect duplication.[5] In fact, by signing the Certification page when filing a group appeal, the Representative certifies that the group issue is not pending in any other appeal for the same period for the same providers.[6] The fact that Case Nos. 19-0463GC and 22-1272GC are each based on different types of final determinations (*i.e.*, Notice in the Federal Register and NPRs, respectively) is irrelevant as explained in Board Rule 4.6.2:

> **4.6.2 Same Issue from Multiple Determinations**
>
> Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR covering the same time period in separate appeals. See Rule 6.3 for instructions on how to add a new determination to a pending individual appeal covering the same time period.

Thus, what matters is the fact that these 2 cases are pursuing the ***same*** *common issue* for the ***same*** year/period.[7]

Further, on December 3, 2019, QRS designated Case No. 19-0463GC fully formed. Once a health chain's CIRP group is fully formed, no other provider in that health chain may pursue the same issue for the same year outside of the CIRP group, per § 405.1837(b)(1), and cannot join the group without leave of the Board pursuant to 42 C.F.R. § 405.1837(e)(1) which states, in pertinent part:

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[3] *See* 42 C.F.R. 405-1837(b)(1)(i).
[4] *See* Board Rule 4.6. *See also* 42 C.F.R. § 405.1837(b).
[5] Had the participant's fiscal year not coincided with the federal fiscal year, the Board would have organized the CIRP group around the federal fiscal year since it is the federal rate that is at issue. For example, if 2 provider's from a chain established a CIRP group based on their fiscal year ending 12/31/2019 for the standardized rates for FFYs 2019 (as it relates to that portion of their fiscal year from 1/1/2019 to 9/30/2019) and for FFY 2020 (as it relates to that portion of their fiscal year from 10/1/2019 to 12/31/2019), then the Board would bifurcate to 2 separate CIRP group – one for FFY 2019 and the other for FFY 2020.
[6] *See* Board Rule 12.10 and Appendix B: Model Form B – Group Appeal Request (Aug. 29, 2018).
[7] *See supra* note 5.

> (1) A provider (or providers) may file a group appeal hearing request with the Board under this section before each provider member of the group identifies or complies with paragraphs (a)(1) and (a)(2) of this section, or before the group satisfies the $50,000 amount in controversy requirement under paragraph (a)(3) of this section. . . . The Board will determine that a group appeal brought under paragraph (b)(1) of this section is fully formed *upon a notice in writing from the group that it is* ***fully formed***. . . . The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed *upon a notice in writing from the group that it is* ***fully formed***, or following an order from the Board that in its judgment, that the group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. *When* the Board has determined that *a group appeal* brought under paragraph (b)(1) of this section *is* ***fully formed****, absent an order from the Board modifying its determination,* ***no other provider*** under common ownership or control *may appeal to the Board the issue* that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.[8]

Accordingly, the Board finds the two Yale-New Haven CY 2019 CIRP groups appealing the IPPS Understated Standardized Payment Amount to be *fully* ***and*** *wholly duplicative*. Further, since Case No. 19-0463GC is fully formed and no Yale New Haven provider may appeal the same issue for the same year outside that CIRP group, the Board hereby **dismisses**, in its entirety, Case No. 22-1272GC consistent with 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(e)(1). In making this dismissal, the Board notes that all of the participants in 22-1272GC are already participants in Case No. 19-0463GC based on their appeal of the Federal Register.

Similarly, the Board **dismisses** Case No. 23-1425 involving a single – the FFY 2019 IPPS standardized amount issue as it relates to its FYE 9/30/2019. As noted in the pertinent facts, Westerly is already pursuing the Standardized Amount issue as a participant in Case No. 19-0463GC, the "Yale New Haven FFY 2019 IPPS Understated Standardized Payment Amount CIRP Group," based on an appeal from the Federal Register. Therefore, since Case No. 19-0463GC is fully formed and no Yale New Haven provider may appeal the same issue for the same year outside that CIRP group, the Board dismisses the NPR-based appeal of the Standardized Amount issue currently pending in Westerly's individual appeal (Case No. 23-1425). Since there are no other issues under appeal in the individual appeal, the Board is closing Case No. 23-1425 and removing it from the Board's docket.

[8] (Emphasis added.) *See also* Board Rules 19.2 (quoting 42 C.F.R. § 405.1837(e)(1)), 19.5 (stating that "[t]he Board has discretion to grant or deny a request to join a fully formed group (CIRP or optional).").

With the closure of Case No. 23-1425, there is no longer a duplication of individual appeals for Westerly, so the Hooper Lundy appeal for Westerly under Case No. 23-1446 will remain pending for the sole issue of the MDH Classification Denial.

Finally, as set forth below, the Board ***admonishes*** *both the parent organization,* ***Yale New Haven Health System, and*** *the Representative,* ***QRS.*** *First, the Board* ***admonishes Yale New Haven Health System*** for filing two (2) separate Designation of Representation letters, within 3 weeks of each other, for the same Provider and FYE and its failure to coordinate with those representatives to ensure that no more than one individual appeals is filed for Westerly for FY 2019. The Board reminds Yale New Haven Health System that it has a responsibility to ensure that it (through its agents) manages its appeals in accordance with the Board Rules and ensure that duplicate appeals are not filed and pursued on its behalf.

Second, the Board ***admonishes QRS*** f*or filing duplicate CIRP groups and for filing duplicate individual appeals on behalf of Westerly and for making* ***untrue certifications*** *with those filings. To this end, the Board directs QRS' attention to the following Board Rules regarding duplicate filings:*

> **4.6 No Duplicate Filings**
>
> **4.6.1 Same Issue from One Determination**
>
> A provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group).
>
> **4.6.2 Same Issue from Multiple Determinations**
>
> Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR covering the same time period in separate appeals. See Rule 6.3 for instructions on how to add a new determination to a pending individual appeal covering the same time period.
>
> **4.6.3 Issue Previously Dismissed or Withdrawn**
>
> Once an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case. For example, if the provider has an issue dismissed from its individual appeal, it may not appeal or pursue that same issue in a group appeal covering the same time period. Refer to Rule 47 for motions for reinstatement.

Similarly, the Board ***reminds QRS*** *that it should exercise diligence and take care when* ***certifying*** *a hospital chain's CIRP group to be* ***fully formed*** because no other provider from that

hospital chain may pursue the same issue for the same year outside of that CIRP group and no provider may be added to a CIRP group *without leave of the Board* consistent with 42 C.F.R. §§ 405.1837(b)(1) and 405.1837(e)(1). The Board recommends that, in exercising diligence prior to making such a certification, QRS review OH CDMS (both for closed and pending cases) and consult with the hospital chain regarding any other relevant appeals for that same period/year by providers in that hospital chain (both closed, pending or yet-to-be filed appeals). In this regard, the Board notes that it is not inclined to reopen the status of a CIRP group if a Representative certifies, in error, a group as fully formed due to administrative oversight.

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

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For the Board:

8/22/2023

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Douglas Payne, Director, Regulatory Reimbursement at Yale New Haven Health System
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RE: ***Board Decision* – SSI Percentage (Provider Specific)**
Barnes Jewish Hospital (Provider Number: 26-0032)
FYE: 12/31/2013
Case Number: 18-0239

Dear Messrs. Kramer and Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 18-0239. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 18-0239

On November 16, 2017, the Board received Provider's Individual Appeal Request appealing their May 30, 2017, Notice of Program Reimbursement ("NPR") for the fiscal year ending December 31, 2013. The initial appeal contained the following two (2) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH Payment – Medicaid Eligible Days

On April 11, 2018, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1. On May 9, 2018, the Provider filed a response to the challenge. On June 5, 2023, the Medicare Contractor filed an updated challenge for issue #1 and for issue #2, Medicaid Eligible Days. On July 5, 2023, Issue 2 was withdrawn by the Provider and on July 18, 2023, the Provider filed a response to the jurisdictional challenge on issue 1. The only remaining issue is Issue 1- DSH/SSI Percentage (Provider Specific).

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 BJC Healthcare. Accordingly, on November 16, 2017, the Provider was directly added to case number 17-0834GC, *QRS BJC 2013 DSH SSI Percentage CIRP*.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 17-0834GC

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[1]

On January 13, 2017, the Board received a request to form a Common Issue Related Party ("CIRP") group appeal, titled *QRS BJC 2013 DSH SSI Percentage CIRP*, which was assigned case number 17-0834GC. The Provider in the instant appeal (18-0239) was directly added to the CIRP group on November 16, 2017, which was the same day the instant appeal was filed.

The DSH/SSI Percentage issue in case number 17-0834GC is described as follows:

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

[1] Individual Appeal Request, Issue 1.

> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") fail to address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> Providers in this case are also seeking resolution of the following aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days[2]

On July 6, 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.

[2] PRRB Case 17-0834GC, Group Issue Statement.

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

MAC's Contentions

The Medicare Contractor filed a Jurisdictional Challenge on June 5, 2023. It argues that Issue 1 should be dismissed in its entirety. First, it argues that "the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is duplicative of the Provider's appeal of the same issue in Group Case No. 17-0834GC . . . ." With regard to the request for SSI realignment, the Medicare Contractor's position is that the Board lacks jurisdiction over this aspect of the issue because there was no final determination over the SSI realignment. It also argues that the Provider "failed to file a complete preliminary position paper including all supporting exhibits to document the merits of its argument in accordance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25."[3]

Provider's Jurisdictional Response

The Provider argues that the issues are not duplicative because "issues #1 and the directly added issue represent different components of the SSI issue, which was specifically adjusted during the audit."[4] 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."[5]

[3] Medicare Administrative Contractor's Jurisdictional Challenge, 1-2 (June 5, 2023).
[4] Jurisdictional Response at 1 (July 18, 2023).
[5] *Id*. at 2.

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 2013, resulting from its understated SSI percentage due to errors of omission and commission."[6]

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*[7] 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 "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[8] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[9] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[10]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 17-0834GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage,

---

[6] *Id*.
[7] 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). !
[8] Issue Statement at 1.
[9] *Id.*
[10] *Id.*

the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 17-0834GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[11], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations, and, to that end, the Provider is pursuing that issue as part of the group under Case 17-0834GC. 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. 17-0834GC.

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. 17-0834GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

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

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

[11] PRRB Rules v. 1.3 (July 2015).
[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).

> 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]

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 17-0834GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5, the Board dismisses this component of the DSH – 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'

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

reply brief included as Exhibit P-2)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

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

> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper ***must*** *set forth the relevant facts* and arguments *regarding* the Board's jurisdiction 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*.[15]

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules, with respect to the purported *Advocate Christ* argument, and dismisses that portion of the issue.

2. Second Aspect of Issue 1

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

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

****

In summary, the Board hereby dismisses the SSI Provider Specific issue from this appeal as it is duplicative of the issue in Case No. 17-0834GC 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. 18-0239 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.

[15] (Emphasis added).

Board Members Participating:

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

For the Board:

8/22/2023

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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Via Electronic Delivery

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RE: ***EJR Determination***
Antelope Valley Hospital (Prov. No. 05-0056)
FYE 6/30/2014
Case No. 16-2425

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the request for expedited judicial review ("EJR") filed by Antelope Valley Hospital ("Provider") on July 25, 2023 in the above-referenced individual appeal pertaining to Provider's fiscal year ("FY") 2014. Set forth below is the decision of the Board to grant Provider's EJR request as it relates to the Part A Days Issue and to deny the remaining aspects of the EJR request as they are not part of this appeal.

I. Procedural History

On September 2, 2016, the Provider's initial representative, Lilian Gong at Gong Nash Pascoe, Inc. ("Gong Nash"), filed an appeal request appealing the Notice of Program Reimbursement ("NPR") dated April 29, 2016 for FY 2014. The appeal request contained the following five (5) issues:

Issue 1	DSH Medicaid Ratio Dual Eligible Part A Days
Issue 2	DSH Medicaid Ratio Medicare Part C Days – ***remanded***
Issue 3	DSH Medicaid Ratio Accuracy of State Data – ***withdrawn***
Issue 4	DSH SSI Ratio Medicare Part A Unpaid Days
Issue 5	DSH SSI Ratio Medicare Part C Days – ***remanded***
Issue 6	DSH SSI Ratio Accuracy of Underlying Data – ***transferred***

The Provider and the Medicare Contractor filed the first page of their preliminary position papers on May 15, 2017 and September 29, 2017, respectively, consistent with the Board Rules then in effect.

On November 2, 2017, the Provider withdrew Issue 3.

On April 28, 2023, the Provider filed its complete final position paper. On May 25, 2023, the Medicare Contractor filed its complete final position paper.

On June 28, 2023, the Provider filed notice, changing its representative from Gong Nash to J.C. Ravindran at Quality Reimbursement Services ("QRS").

On July 18, 2023, QRS transferred Issue 6 to the optional group under Case No. 23-1525G entitled "QRS CY 2014 DSH SSI Unduly Narrow Definition of SSI Entitlement Group."

On July 24, 2023, QRS filed correspondence acknowledging that the instant appeal only had pending Issues 1, 2, 4 and 5 and requested that Issues 2 and 5 (concerning Part C days) be transferred to the optional group under Case No. 21-1510G. [1]

On July 25, 2023, QRS filed the instant EJR request. While the EJR Request does not specify which issue(s) it relates to, the only issues to which it can apply are Issues 1 and 4 since (a) QRS had already requested transfer of Issues 2 and 5 the day before; and (b) the EJR request concerns, in part, the substance of Issues 1 and 4. As discussed *infra*, the Board finds that the appeal does not contain the remaining parts of the EJR request.

On August 7, 2023, the Board denied the transfer of the Part C Days issues (Issue 2 and 5) and instead remanded them to the Medicare Contractor as required by CMS Ruling 1739-R. As a result, the sole remaining issues in this appeal are Issues 1 and 4 entitled "DSH Medicaid Ratio Dual Eligible Part A Days" and "DSH SSI Ratio Medicare Part A Unpaid Days" respectively. This means that the EJR request can only relate to Issues 1 and 4.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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[1] *See also*, PRRB Case 16-2425, Request to Re-Open Closed Groups to Allow Transfer (July 24, 2023) (the request to reopen also acknowledges that "QRS is requesting separately, expedited judicial review for the following two issues: Issue #1 DSH - Medicaid Ratio: Dual Eligible Part A Days and Issue #4 SSI Medicare Part A Unpaid Days.").
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 C.F.R. 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); § 412.106.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] 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.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[12]

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[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation (FY 2005 IPPS Final Rule)

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[13] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[14]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[15] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[16] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[17]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[18] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[19] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[20]

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[13] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* at 27207-27208.
[18] *Id.* at 27207-08.
[19] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[20] 68 Fed. Reg. at 27208.

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[21] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[22] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[23] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[24]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[25] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[26]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[27]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on

[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[26] *Id.*
[27] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[28]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[29]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[30] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[31] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[32]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

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[28] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[29] *Id.* at 49099 (emphasis added).
[30] *Id.*
[31] *See id.* at 49099, 49246.
[32] (Emphasis added.)

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[33]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[35] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[36] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[37] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[38] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[39] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[40] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[41] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[42]

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[33] (Emphasis added.)
[34] *Id.*
[35] 317 F. Supp. 3d 168 (D.D.C. 2018).
[36] *Id.* at 172.
[37] *Id.* at 190.
[38] *Id.* at 194.
[39] *See* 2019 WL 668282.
[40] 718 F.3d 914 (2013).
[41] 657 F.3d 1 (D.C. Cir. 2011).
[42] 718 F.3d at 920.

In the third case, *Empire Health Found. v. Price* ("*Empire*"), the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[43] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[44] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that: (1) without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments; and (2) interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[45] and that the regulation is procedurally invalid.[46]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[47] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[48] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[49] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hosp. & Health Ctr. v. Shalala* ("*Legacy Emanuel*")[50] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[51] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[52] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[53] Accordingly, the Ninth Circuit took the following actions to implement its holding:

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[43] 334 F. Supp. 3d 1134, 1141 (E.D. Wash. 2018).
[44] *Id.*
[45] *Id.* at 1162.
[46] *Id.* at 1163.
[47] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[48] *Id.* at 884.
[49] *Id.* at 884.
[50] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[51] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[52] *Id.* at 886.
[53] *Id.*

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

The Secretary appealed the Ninth Circuit decision and the United States Supreme Court subsequently issued its decision in *Becerra v. Empire Health Foundation*[54] ("*Empire Health"*) finding that the Secretary "correctly construes the statutory language at issue."[55] The Court found that: (1) the structure of the DSH provisions supported the Secretary, summarizing that "Counting everyone who qualifies for Medicare benefits in the Medicare fraction—and no one who qualifies for those benefits in the Medicaid fraction—accords with the statute's attempt to capture, through two separate measurements, two different segments of a hospital's low-income patient population"; and (2) being "entitled" to Medicare benefits means meeting the basic statutory criteria, not actually receiving payment for a given day's treatment.[56] Nor did the Court find any credence in the argument that "entitled" was modified by the statute by adding "(for such days)". Though this parenthetical does direct the Secretary to evaluate a patient's status on a given day, it does not invite an evaluation of whether a patient *received* Part A payments, but rather whether it is qualified to receive part A payments.[57] Based on the foregoing, the Court reversed the Ninth Circuit's *Empire* decision and remanded the case for further proceedings.[58]

On remand, the Ninth Circuit is now addressing the appellant's "remaining challenge."[59] Specifically, it noted that neither the Ninth Circuit or the Supreme Court addressed the appellant's alternative argument concerning the Secretary's calculation of patient days for those patients "entitled to supplemental security income [SSI] benefits," which also factors into the Medicare fraction.[60] The argument claims that there is an inconsistency in between "entitled to Medicare" and "entitled to SSI." As discussed above, "entitled to Medicare" Part A has been deemed to mean legally entitled to benefits, regardless of whether payment was actually made, but the Secretary's policy for SSI benefits includes those patient days only when SSI benefits are paid to an individual on a given month, not merely when they are eligible for benefits.[61] Consideration of this issue is now pending before the District Court for the Eastern District of Washington.[62]

As of the date of this decision, the Secretary has not changed his position on the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule).

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[54] 142 S.Ct. 2354 (2022).
[55] *Id.* at 2362.
[56] *Id.*
[57] *Id.* at 2365.
[58] *Id.* at 2368.
[59] *Empire Health Found. v. Azar*, 2022 WL 17411382, *1 (9th Cir. 2022).
[60] *Id.*
[61] *Id.*
[62] *Id.* at *2. Following the Supreme Court's remand in *Empire*, the district court initially dismissed this alternative argument for lack of subject matter jurisdiction. The Ninth Circuit reversed that decision and ordered the district court "to consider the argument in the first instance and to obtain supplemental briefing on the impact of the Supreme Court's ruling . . . ." *Id.*

C. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation (FY 2011 IPPS Final Rule)

As discussed above, the Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[63] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[64]

This particular issue involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

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[63] (Emphasis added.)
[64] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[65] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[66] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[67]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[68] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[69]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[70] and may terminate,[71] suspend[72] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[73] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[74]
2. The individual fails to apply for other benefits to which the individual may be entitled;[75]
3. The individual fails to participate in drug or alcohol addiction treatment;[76]
4. The individuals is absent from the United States for more than 30 days;[77] or
5. The individual becomes a resident of a public institutions or prison.[78]

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[65] 42 U.S.C. § 1382.
[66] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[67] 20 C.F.R. § 416.202.
[68] 42 U.S.C. § 426.
[69] 42 U.S.C. § 426-1.
[70] 20 C.F.R. § 416.204.
[71] 20 C.F.R. §§ 416.1331-1335.
[72] 20 C.F.R. §§ 416.1320-1330.
[73] 20 C.F.R. § 1320.
[74] 20 C.F.R. § 416.207.
[75] 20 C.F.R. § 416.210.
[76] 20 C.F.R. § 416.214.
[77] 20 C.F.R. § 416.215.
[78] 20 C.F.R. § 416.211.

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[79]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[80] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[81] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[82] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[83] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[84]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[85]

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[79] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[80] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[81] *Id.*
[82] *Id.*
[83] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[84] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[85] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "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;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[86] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[87] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[88]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[89] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[90]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[91] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[92] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02

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(4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[86] CMS-1498-R at 5.

[87] *Id.*

[88] *Id.* at 5-6.

[89] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[90] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[91] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[92] *Id.* at 50280.

"accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[93] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[94] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[95]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[96] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[97] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[98]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[99]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the NPR at issue was issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Provider for the fiscal year at issue.[100]

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[93] *Id.* at 50280-50281.
[94] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[95] *Id.* at 50285.
[96] CMS-1498-R at 6-7, 31.
[97] *Id.* at 28, 31.
[98] 75 Fed. Reg. at 24006.
[99] CMS-1498-R2 at 2, 6.
[100] CMS published the SSI ratios for FY 2014 on or about July 5, 2016. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

III. THE PROVIDER'S APPEAL REQUEST AND ITS EJR REQUST

The EJR requests states that it pertains two separate issues identified as the "Part A Days Issue" and the "SSI Days Issue" and, for each issue, it is challenge a policy identified as the "Part A Days Policy" and "SSI Days Policy" respectively. The following chart breaks this out as follows:

	Part A Days Issue	**SSI Days Issue**
Issue that is alleged to have been included in the Provider's Appeal Request[101]	"[W]hether patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation"	"[A]lternatively, whether all of the Provider's patients entitled to supplemental security income ("SSI") should be included in the DSH calculation"
Issue for the EJR request	"Part A Days Issue" Description – "Whether patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation?"	"SSI Days Issue" Description – "Alternatively, if 'entitled' to Medicare Part A includes patients for whom no payment is made, whether the numerator of the Medicare fraction of the Medicare DSH percentage should include all of the Provider's patients entitled to supplemental security income ("SSI"), as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
Policy Being Challenged	"Part A Days Policy" Description – "The Provider challenges the policy of the Centers for Medicare & Medicaid Services ("CMS") to include in the DSH Medicare Fraction all patients enrolled in Part A without regard to whether a Part A payment was made."	"SSI Days Policy" Description – "Alternatively, if "entitled" means all such Part A patients, then "entitled" to SSI should not be limited to only three codes: CO1, M01 and M02 to identify persons entitled to SSI. See 75 Fed. Reg. at 50280-81 (August 16, 2010)."
Final Rule Being Challenged	FY 2005 IPPS Final Rule, 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) wherein the "Part A Days Policy" was finalized.	FY 2011 IPPS Final Rule, 75 Fed. Reg. 50042, 50280-81 (Aug. 16, 2010) wherein the "SSI Days Policy" was finalized.

[101] The quotes were taking from the EJR request as follows: first row from the EJR Request at 1 (footnote at end of second quote omitted); the second row from the EJR Request at 1-2; the third row from the EJR request at 2. For the fourth row, *see* EJR Request at 2, 9, 11.

A. Appeal Request for Issues 1 and 4:

In its appeal request, the Provider describes Issue 1 (DSH Reimbursement - Medicaid Ratio: Dual Eligible Part A Days) as follows:

> **Description of the Issue**
>
> *The Provider contends* that days related to dual eligible patients who have exhausted their Medicare Part A benefits should be ***included*** *in the Medicaid Fraction* for purposes of calculating DSH Reimbursement.
>
> Dual eligible days include patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the Medicare Provider Analysis and Review ("MEDPAR") system. These days are not allowed as "Medicare eligible" by the MAC in the Medicaid numerator, hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid but have exhausted their Medicare benefits ("Exhausted Days") or Medicare was the secondary payer ("MSP Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, vacated and remanded, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("Jersey").
>
> Thus, in accordance with the Board's holding in the Edgewater, the *Medicaid ratio should* ***include*** *all "Exhausted Days".*[102]

[102] Appeal Request, Tab 3, Issue 1 (Sept. 2, 2016) (bold and underline emphasis in title in original, bold and italics emphasis in body added).

The Provider describes Issue 4 ("DSH Reimbursement - SSI Ratio: Medicare Part A Unpaid Days") as follows:

> **Description of the Issue**
>
> Under current CMS methodology (as outlined in CMS Ruling 1498-R), the SSI ratios are calculated to include "the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction (provided that the patient was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted." CMS' view is that a beneficiary remains entitled to Medicare Part A even if their Part A benefits are exhausted.
>
> ***The Provider's view*** *is that once their Part A benefits are exhausted, the beneficiary is no longer "entitled" to Part A*. The plain language of the Medicare statute defines entitlement to benefits under Part A as the right to have payment made on the patient's behalf for covered services.
>
> Various U.S. courts have found that the term "entitlement" denotes a right to have payment made under Part A of Title XVIII. *Since Medicare Part A benefits have been exhausted,* ***the patients whose days are at issue*** *were clearly not entitled to have payment made on their behalf for those days, therefore, the days should be* ***excluded*** *from the SSI Fraction*.[103]

In summary:

- Issue 1 claims that dually eligible patients who have exhausted their Medicare Part A benefits (as well as Medicare Secondary Payor days) should be ***included in*** the numerator of ***the Medicaid Fraction***;
- Issue 4 claims that patients who have exhausted their Medicare Part A benefits are not "entitled" to Part A and, thus, should be ***excluded from*** the numerator and denominator of ***the Medicare Fraction***; and
- Together, both issues relate to which fraction, if any, should capture exhausted and MSP days in the DSH calculation, which turns on when a beneficiary is "entitled" to Medicare Part A benefits.

Significantly, neither Issue 1 nor Issue 4 addresses or asserts that the numerator of the SSI fraction is *underinclusive* of SSI days or that the phrase "entitled to [SSI] benefits" should be more broadly

[103] Appeal Request, Tab 3, Issue 4 (Sept. 2, 2016) (bold & underline emphasis in title in original, bold & italics emphasis in body added).

interpreted to include SSI eligible individuals. As such, neither Issue 1 nor Issue 4 addresses the "SSI Days Issue" set forth in the EJR Request.

B. Position Papers

The Provider's Final Position Paper, filed April 28, 2023, is 123 pages in length covering the five issues then-existing in this appeal when that position paper was filed (the 2 Part C days issues were later remanded and the SSI Ratio – Accuracy of Underlying Data has now been transferred). It also provides extensive discussion on the history of different aspects of the DSH payment, though some of the discussion is not directly relates to the issues appealed in the case but rather raises new issues not included in the appeal request per the requirements at 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8. Most of the position paper (pages 55 to 123) is devoted to Issue 6 entitled "SSI Ratio: Accuracy of Underlying Data" which transferred to an optional group (Case No. 23-1525G) ***6 days prior to*** the instant EJR request being filed.[104] In discussing Issues 1 and 4, the position paper specifically discusses the FY 2005 and FY 2011 IPPS Final Rules, outlined above.

For Issue 1 (Medicaid Ratio: Dual Eligible Part A Days), the Provider expands on its issue statement explaining that it concerns both exhausted days and MSP days – both of which are scenarios where a party other than Medicare has made payment for an inpatient hospital stay.[105] It recounts how the FY 2005 IPPS Final Rule deleted the word "covered" from 42 C.F.R. § 412.106(b)(2)(i), resulting in both exhausted and MSP days being included in the Medicare fraction. The Provider believes, for many reasons, that these days should be excluded from the Medicare fraction but included in the Medicaid fraction.[106] It acknowledges that the *Empire* litigation resulted in a finding by the Supreme Court that the Part A Days Policy in the FY 2005 IPPS Final Rule was *substantively valid* and, as such, concedes that the substantive validity is resolved.

With respect to the procedural validity of the Part A Day Policy, the Provider acknowledges that the U.S. Court of Appeals for the Ninth Circuit held that, in *Empire*, the Part A Days Policy issued in the FY 2005 IPPS Final Rule was procedurally valid and that this portion of its *Empire* decision was not reviewed by the Supreme Court.[107] The Provider further asserts that the procedural validity issue has not been review outside the Ninth Circuit with one exception involving that the U.S. District Court for the District of Columbia which, in 2018, found it to be procedurally valid in *Stringfellow*.[108] In its Final Position Paper, the Provider argues that the regulations set forth in the FY 2005 IPPS Final Rule were improperly promulgated and should be vacated. It claims there was insufficient notice and comment and that the rule is not the product of reasoned decision making.[109]

In its final position paper, the Provider characterizes Issue 4 (SSI Ratio: Medicaid part A Unpaid Days) as alternative argument stating "[i]n the event of a holding that 'entitled' to Part A Days does not require Part A payment, the Provider in the alternative contends that 'entitled' to SSI must

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[104] As noted above, the transfer of Issue 6 occurred on July 18, 2023 and the EJR request was filed on July 24, 2023.
[105] Provider's Final Position Paper, 28 (Aug. 28, 2023) ("Provider's FPP").
[106] *Id.* at 28-29.
[107] *Id.* at 29.
[108] *Id.* at 29-30.
[109] *Id.* at 30-34.

have the identical meaning as 'entitled' to Part A." It describes the data match process laid out in the FY 2011 proposed and final rules and takes issue with the decision of CMS to only use three SSI payment status codes to identify persons "entitled to SSI." Based on the proceedings in *Empire*, the Provider argues that CMS is interpreting "entitled" to SSI differently than "entitled" to Part A, despite both terms being used in the same regulation at 42 C.F.R. § 412.106(b)(2)(i)(B). It concludes that all patients who are enrolled in SSI should be included when counting patients "entitled" to SSI.[110] However, the final position paper does not discuss how this ties back to its original description of Issue 4 in its appeal request which simply sought exclusion of no-pay Part A days from the SSI fraction:

> ***The Provider's view*** is that once their Part A benefits are exhausted, the beneficiary is no longer "entitled" to Part A. . . .
>
> Since Medicare Part A benefits have been exhausted, the patients whose days are at issue were clearly not entitled to have payment made on their behalf for those days, *therefore, the days should be* ***excluded*** *from the SSI fraction*.[111]

Finally, the Provider raises this ***same*** SSI "entitled" issue in the context of Issue 6 and devotes many pages to it (in contrast to the argument on Issue 4 which is 7 pages long). Significantly, the 75 pages of argument on Issue 6 match the topic areas appear to line up with the issue statement for the optional group (Case No. 23-1525G) to which the Provider transferred Issue 6.[112] Significantly, the EJR request appears to recognize the "transfer[] the SSI Days Issue to a pending Group" when discussing the Board's jurisdiction over the Provider's appeal:

> As evidenced by the Model Form A (Exhibit 2), the Provider *timely filed their appeal of* ***the SSI Days Policy*** by (a) filing individual appeals within 180 days of the notice of program reimbursement ("NPR") (or timely adding the SSI Days Issue to a timely filed appeal) ***and*** *then transferring* ***the SSI Days Issue*** *to a pending Group* or (b) directly appealing the SSI Days Issue to a pending Group within 180 days of the NPR.[113]

Thus, the EJR request ***concedes*** the SSI Days Issue is not currently pending in the instant case.

C. EJR Request

The Provider filed an EJR Request which alleges that it *appealed*:

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[110] *Id.* at 52-55.
[111] (Emphasis added.)
[112] The Board has not fully reviewed Case No. 23-1525G to confirm whether the issue statement for Case No. 23-1525G and the final position paper in this case, as it relates to Issue 6, fully line up. However, it is clear that both discuss the SSI Days Issue.
[113] EJR Request at 4 (emphasis added).

> [W]hether patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the [DSH] calculation ***or****, alternatively*, whether all of the Provider's patients entitled to [SSI] should be included in the DSH calculation.[114]

The Provider does not specify which issues from the original appeal are encompassed in this EJR Request, but it appears to be seeking EJR over the substance of issues 1 and 4.[115] The EJR Request confusingly argues that these two issues are really two components of a single issue, but that "[i]f, however, the Board finds that these two issues are distinct the Provider will request that the Board bifurcate into two separate groups." The Board notes that this is an individual appeal. This is likely due to the recycling of briefs.

The issue arises again, and more importantly, when discussing the *Empire* decision, where the EJR Request ***incorrectly*** asserts that "the Provider is ***not*** located in the jurisdiction or bound by the decisions of [the Ninth Circuit in *Empire* or the D.C. District Court in *Stringfellow*]."[116] The Provider is located in California, which is in the Ninth Circuit and, as such, is bound by the Ninth Circuit's holding in *Empire* that the Part A Days Policy in the FY 2005 IPPS Final Rule is procedurally valid. Additionally, despite the contention that the entirety of its EJR request covers just a "single" issue, the Provider outlines two very specific challenges to "The Part A Days Issue" and the "SSI Days Issue" which Board Rule 8 specifically identifies as two separate issues.

The EJR Request, in large part, repeats the arguments made in the Final Position Paper filed just a few months prior. For what it describes as the "Part A Days Issue," the Provider outlines the history of the Part A Day Policy finalized in the FY 2005 IPPS Rule, acknowledges and concedes that *Empire* found the Part A Days Policy was substantively valid, but is now arguing it is *procedurally* invalid.[117]

For what it describes as the "SSI Days Issue," the Provider outlines the history of the FY 2011 IPPS Rule and argues that the three codes used for CMS' data matching process set forth therein do not capture all days for patients who are "entitled to SSI." The argument is grounded in the claim that the Supreme Court's holding in *Empire* as to the meaning of "entitled" in the phrase "entitled to benefits under [Medicare] part A" should be identical to the meaning that same term in the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).[118]

The Provider concludes that the Board lacks authority to decide its challenge to the Part A Days Policy and the SSI Days Policy and, therefore, the Board should grant EJR.

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[114] Provider's Request for Expedited Judicial Review, 1 (July 25, 2023) ("EJR Request") (emphasis added).
[115] *See* PRRB Case 16-2425, Request to Re-Open Closed Groups to Allow Transfer (July 24, 2023) ("QRS is requesting separately, expedited judicial review for the following two issues: Issue #1 DSH - Medicaid Ratio: Dual Eligible Part A Days and Issue #4 SSI Medicare Part A Unpaid Days.").
[116] *Id.* at 7.
[117] *Id.* at 5-11.
[118] *Id.* at 11-18.

IV. DECISION OF THE BOARD

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

The sole remaining issues in this appeal are Issues 1 and 4. As such, the EJR request must relate to these issues. Indeed, on July 24, 2023, the day before filing the EJR request, QRS file correspondence acknowledging that the instant appeal only had pending Issues 1, 2, 4 and 5 and requested that Issues 2 and 5 (concerning Part C days) be transferred to the optional group under Case No. 21-1510G. Shortly thereafter, on August 7, 2023, the Board denied the transfer request for Issues 2 and 5 concerning Part C Days and remanded the Part C Day issues to the Medicare Contractor pursuant to CMS Ruling 1739-R.

While the EJR Request should but does not specify to which issue(s) from the appeal request it relates, the only issues to which it can apply or relate are Issues 1 and 4 since: (a) QRS had already requested transfer of Issues 2 and 5 the day before; and (b) the EJR request concerns, in part, the substance of Issues 1 and 4. Indeed, to the extent the Provider were to assert that the EJR request does not relate to these 2 issues, then the Provider had an obligation to explain to what issues the EJR request relates because this is a necessary part of an EJR request at Board Rule 42. Board Rule 42.3 specifies that the EJR request must "[i]dentif[y] the issue for which EJR is requested" and "[d]emonstrate[] that the Board has jurisdiction."[119]

As discussed *infra*, the Board reviewed Issues 1 and 4 and finds that they only address the Part A Days Issue and do ***not*** address the SSI Days Issue.

A. Background on Jurisdiction for Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[120]

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[119] Board Rule 42.3 makes clear that an EJR request must explain how the Board has jurisdiction over the issue for which EJR is being request. In order to have jurisdiction over an issue, it must have been properly appealed and set forth in the appeal request in the first instance. In this regard, 42 C.F.R. § 405.1835(b) describes the claim filing requirements for each issue being appealed. However, the appeal request does not tie the SSI Days Issue back to the appeal request and does not describe how that issue was part of the original appeal request and how the SSI Days Issue is still currently pending in the individual appeal.

[120] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The

In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[121]

On August 21, 2008, revisions to the Board's governing regulations became effective.[122] One of the revised regulations was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[123] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[124]

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

B. Board Analysis on the Scope of the EJR Request as it Relates to the Appealed Issues Remaining in this Case

As discussed *supra*, the two issues from the Provider's original appeal request (filed September 2, 2016) for which it is now requesting EJR can be summarized as follows:

- Issue 1 claims that dually eligible patients who have exhausted their Medicare Part A benefits (as well as Medicare Secondary Payor days) should be ***included in*** the numerator of ***the Medicaid Fraction***, and

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Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

[121] *Bethesda at 1258-59.*

[122] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

[123] 201 F. Supp. 3d 131 (D.D.C. 2016).

[124] *Id.* at 142.

- Issue 4 claims that patients who have exhausted their Medicare Part A benefits are not "entitled" to Part A and, thus, "should be ***excluded from*** [the numerator and denominator of} ***the SSI Fraction***,"[125] and

- For both of these issues, the Provider identifies the days at issue as involving "dual eligible patients who have exhausted their Medicare Part A benefits"[126] and this is based on "[t]he Provider's view . . . that once their Part A benefits are exhausted, the beneficiary is no longer 'entitled' to Part A."[127]

- Together, both issues relate to which fraction, if any, should capture exhausted and MSP days in the DSH calculation, which turns on when a beneficiary is "entitled" to ***Medicare Part A benefits***.

Both of these issues relate to the interpretation of entitled to Medicare Part A benefits. Specifically, Issue 4 focuses on interpreting the phrase "entitled to benefits under [Medicare] part A" as used in § 1395ww(d)(5)(F)(vi)(I) for the SSI fraction (Issue 4); and Issue 1 focuses on interpreting the phrase "*no*t entitled to benefits under [Medicare] part A"[128] as used in § 1395ww(d)(5)(F)(vi)(I) for the Medicaid fraction SSI fraction (Issue 1).

Significantly, neither issue discusses the SSI Days Issue, *i.e*., what the phrase "entitled *to* ***supplemental security income*** *[i.e., SSI] benefits*" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means and contending that it is interpreted to narrowly such that the numerator of the SSI fraction is undercounted.[129] The phrase "entitled to [SSI] benefits" pertains to the numerator of the SSI fraction. More specifically, Issue 1 only relates to the Medicaid fraction and, as such, cannot encompass the SSI Days Issue. Similarly, while Issue 4 relates to the SSI fraction, the Appeal Request makes clear that Issue 4 only relates to dual eligible patients who have exhausted their Medicare Part A benefits" and requests that this class of days be "*excluded* from the SSI fraction."[130] Issue 4 cannot relate to the SSI Days Issue since it does contend that the numerator of the SSI fraction is undercounted and/or that the phrase "entitled to [SSI] benefits" is interpreted too narrowly.

Based on the above discussion, it is clear that the issue statements for Issues 1 and 4 did not include the SSI Days Issue and did not meet the following claim filing requirements in 42 C.F.R. § 405.1835(b) (2014):

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[125] Appeal Request at Tab 3, Issue 4 (emphasis added).
[126] Appeal Request at Tab 3, Issue 1.
[127] *Id.* at Tab 3, Issue 4. *See also id.* (stating: "Various U.S. courts have found that the term 'entitlement' denotes a right to have payment made under Part A of Title XVIII. *Since Medicare Part A benefits have been exhausted*, the patients whose days are at issue were clearly not entitled to have payment made on their behalf for those days, therefore, the days should be excluded from the SSI Fraction." (emphasis added)).
[128] (Emphasis added.)
[129] They simply do not discuss, involve, or implicate in any way the interpretation of "entitled to SSI" and the FY 2011 IPPS Final Rule.
[130] (Emphasis added.)

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the contractor's or Secretary's determination under appeal.
>
> (2) **An explanation (for <u>each</u> specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) **Why the provider believes Medicare payment is incorrect for <u>each</u> disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) **How and why the provider believes Medicare payment must be determined <u>differently</u> for <u>each</u> disputed item**.
>
> (iii) If the provider self-disallows a specific item, **a description of the nature and amount of <u>each</u> self-disallowed item** and the reimbursement or payment sought for the item.
>
> (3) A copy of the contractor or Secretary determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[131]

Here, neither Issue 1 nor Issue 4 relate to the SSI Days Issue since the issue statement for these issues in the appeal request fails to explain "why Medicare payment is incorrect" in connection with this issue (*i.e.*, because "entitled to [SSI] benefits" is interpreted too narrowly) or similarly "how and why the provider believes Medicare payment must be determined differently" for this

[131] (Bold and underline emphasis added, italics in original.)

issue. Further, as the SSI Days Issue is a self-disallowed item,[132] it further fails to give "a description of the nature and amount" involved with the SSI Days Issue as there is no separate amount in controversy calculation for the SSI Days Issue (which again does not involve excluding days from the SSI fraction but rather increasing the numerator of the SSI fraction).

Indeed, the Board finds that, to the extent the SSI Days Issue was ever part of this appeal, it was transferred ***prior to*** the EJR request being filed.[133] As discussed *supra*, in the final position paper, the Provider raises this ***same*** SSI "entitled" issue in the context of Issue 6 and the Provider transferred Issue 6 the optional group (Case No. 23-1525G). Significantly, the 67 pages of argument on Issue 6 in that position paper appear to line up with the issue statement for the optional group (Case No. 23-1525G) to which the Provider transferred Issue 6.[134] Significantly, the EJR request appears to recognize the "transfer[] the SSI Days Issue to a pending Group" when discussing the Board's jurisdiction over the Provider's appeal:

> As evidenced by the Model Form A (Exhibit 2), the Provider *timely filed their appeal of* ***the SSI Days Policy*** by (a) filing individual appeals within 180 days of the notice of program reimbursement ("NPR") (or timely adding the SSI Days Issue to a timely filed appeal) ***and*** *then transferring* ***the SSI Days Issue*** *to a pending Group* or (b) directly appealing the SSI Days Issue to a pending Group within 180 days of the NPR.[135]

As a provider cannot pursue the same issue for the same year in more than one appeal (*see* Board Rule 4.6), it is clear that the EJR request itself ***concedes*** the SSI Days Issue is not currently pending in the instant case. Accordingly, the Board finds the SSI Days issue is not currently part of the appeal and denies the EJR as it relates to the SSI Days Issue and the SSI Days Policy.[136]

In summary, the Board reviewed the appeal request to confirm whether the Board has jurisdiction over the Part A Days Issue and finds that it does. The sole remaining issues in this appeal are Issues 1 and 4 and, as set forth below, the Board has determined that these issue solely relate to the meaning of "entitled to Part A" is governed by CMS Ruling CMS-1727-R since the Providers are challenging the Secretary's interpretation of this phrase as used in the Part A Days Policy finalized/adopted in the FY 2005 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual

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[132] In using the term "self-disallowed," the Board is referring to the fact that the Provider must accept the SSI rate published by CMS and has no ability to otherwise alter it or claim something different when filing its cost report.
[133] In making this finding, the Board is not ruling that Issue 6 encompasses the SSI days issue and will review that as part of the jurisdictional review of the optional group.
[134] The Board has not fully reviewed Case No. 23-1525G to confirm whether the issue statement in Case No. 23-1525G and final position paper in this case as it relates to Issue 6 fully line up. However, it is clear that both discuss the SSI Days Issue. Similarly, the Board has ***not*** yet reviewed Issue 6 to confirm that the jurisdictional and claim filing requirements in 42 C.F.R. §§ 405.1837(a)-(b) and 405.1840 have been met as that will be done in the group.
[135] EJR Request at 4 (emphasis added).
[136] *See supra* note 134 and accompanying text.

appeal. The appeal was timely filed and no jurisdictional impediments have been identified for the Provider. Based on the above, the Board finds that it has jurisdiction for the above-captioned individual appeal as it relates to the Part A Days Issue.

C. Board analysis of the EJR Request

The Provider's Final Position Paper and EJR Request were both filed in 2023 ***after*** the Supreme Court's decision in *Empire*. As a result, they both dedicate a significant amount of discussion to the meaning of "entitled to benefits under [Medicare] part A" as it relates to the interpretation of the Part A Days Policy finalized/adopted in the FY 2005 IPPS Final Rule. Further, as outlined, *supra*, the Part A Days Issue stated in the EJR Request involves the Part A Days Policy finalized in the FY 2005 IPPS Final Rule, which was the subject of extensive litigation. The Supreme Court has *definitively* concluded in *Empire* that this rule is substantively valid. Indeed, in both its final position paper and EJR request, the Provider acknowledges that the Supreme Court in *Empire* made this finding and, as such, ***concedes*** that the Part A Days Policy is substantively valid. Accordingly, what is left in dispute is whether the finalization/adoption of the Part A Days Policy in the FY 2005 IPPS Final Rule was *procedurally* valid.

With respect to the procedural validity issue, the Provider acknowledges that, while the Supreme Court did not consider in *Empire* any challenge to the *procedural* validity of the Part A Days Policy as finalized/adopted in the FY 2005 IPPS Final Rule, the Ninth Circuit did so and it determined that the adoption/finalization of the Policy was procedurally valid.[137] While the EJR Request ***incorrectly*** notes that "the Provider is ***not*** located in the jurisdiction or bound by the decisions of [the Ninth Circuit in *Empire* or the D.C. District Court in *Stringfellow*,]"[138] the Provider is located in the Ninth Circuit since it is located in California and, as such, is bound by the Ninth Circuit.[139] However, none of these facts or discrepancies prevent the Provider from pursuing an EJR request on the procedural validity of the finalization/adoption of the Part A Days Policy in the FY 2005 IPPS Final Rule.

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[137] 958 F.3d. at 884.

[138] EJR Request at 7 (emphasis added).

[139] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor Room Days Grps. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Further, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit if the D.C. Circuit has addressed the issue (which may be in additive to the Circuit in which it is located if it has also addressed the issue). *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007). For example, prior to the Supreme Court's decision in *Your Home Visiting Nurse Servs. v. Shalala*, 119 S. Ct. 930 (1999), CMS (then HCFA) issued guidance creating an exception for providers located in the Ninth Circuit Court of Appeals based on the Ninth Circuit's decision in *Your Home* which was later reviewed and overturned by the Supreme Court. *See* Provider Reimbursement Manual, CMS Pub 15-1, Ch. 29, Transmittal No. 410 (Aug. 1, 1999) (revising § 2924.4 to "delete[] the exception for providers located within the Ninth Circuit Court of Appeals when providing that a decision denying jurisdiction of an appeal of an intermediary's refusal to reopen a cost report is not subject to judicial review, pursuant to *Your Home Visiting Nurse Services, Inc. v. Shalala*, 119 S.Ct. 930 (1999).").

To the extent the *procedural* validity of the Secretary's finalization/adoption of the Part A Days Policy (and related regulation revisions) in the FY 2005 IPPS Final Rule is challenged, it would appear that a successful challenge would only result in reinstatement of the prior policy which was simply to ***not*** count no-pay Part A days in either the Medicare or Medicaid fractions and, as such, would have no impact on the Medicaid fraction. The Board views the challenge to the Part A Days Policy to include no pay Part A days in the Medicare fraction (Issue 4) as a *separate issue* from the inclusion of the subset of those days in the Medicaid fraction (Issue 1). In support of this position, the Board points to the Ninth Circuit's decision in *Empire* where they overturned the Part A Days Policy but simply reverted to the prior policy that resulted in no-pay Part A days being counted in neither fraction.[140] 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.[141]

42 C.F.R. § 405.1867 specifies that "[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 . . . .*"[142] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) challenging the *procedural* validity of the finalization/adoption of the Part A Days Policy in the FY 2005 IPPS Final Rule and related revisions made to § 412.106(b)(2)(i) therein, so as to exclude no-pay Part A days from the SSI fraction; and (2) seeks the inclusion of the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction.

Based on the foregoing, the Board finds that the Provider is seeking EJR over Issues 1 and 4 in its appeal[143] and that these two issues *solely* concern the *procedural* validity of finalization/adoption of the Part A Days Policy (and related revisions to the regulations) in the FY 2005 IPPS Final Rule. Based on the above, the Board finds that EJR is appropriate for the Part A Days Issue and calendar year under appeal in this case.

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[140] *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).

[141] 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.

[142] (Emphasis added.)

[143] *See* PRRB Case 16-2425, Request to Re-Open Closed Groups to Allow Transfer (July 24, 2023) (the reopening request acknowledges that "QRS is requesting separately, expedited judicial review for the following two issues: Issue #1 DSH - Medicaid Ratio: Dual Eligible Part A Days and Issue #4 SSI Medicare Part A Unpaid Days.").

In summary, the Board finds that:

1) It has jurisdiction over the Part A Days Issue for the subject year and that the Provider in Case No. 16-2425 is entitled to a hearing before the Board; however, it does not have jurisdiction over the SSI Days Issue since that issue is not pending in this case and, as such, denies the EJR request as it relates to the SSI Days Issue.[144]

2) Based upon the Provider's assertions regarding the Part A Days Policy (as finalized/adopted in the FY 2005 IPPS Rule) which was codified in 42 C.F.R. § 412.106(b)(2)(i) by the FY 2005 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal questions of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule in connection with the Part A Days Policy) is ***procedurally*** valid and, if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction.

Accordingly, the Board finds that the questions of the ***procedural*** validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule in connection with the Part A Days Policy) ***and***, if successful, what policy should then apply, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review.

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

Board Members Participating:

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

For the Board:

8/24/2023

X Clayton J. Nix

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

[144] As discussed *supra,* the Board finds that: (1) the interpretation of, validity of, and/or policies set forth in the FY 2011 IPPS Final Rule is not part of this appeal and denies its EJR Request for that issue; (2) to the extent it could have been part of the appeal, it was part of Issue 6 which was transferred to Case No. No. 23-1525G several days prior to the EJR request filing; and (3) the EJR request specifically concedes that the SSI Days Issue was transferred.

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***EJR Determination***
Antelope Valley Hospital (Prov. No. 05-0056)
FYE 6/30/2013
Case No. 16-2426

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the request for expedited judicial review ("EJR") filed by Antelope Valley Hospital ("Provider") on July 25, 2023 in the above-referenced individual appeal pertaining to Provider's fiscal year ("FY") 2013. Set forth below is the decision of the Board to grant Provider's EJR request as it relates to the Part A Days Issue and to deny the remaining aspects of the EJR request as they are not part of this appeal.

I. Issue in Dispute

On September 2, 2016, the Provider's initial representative, Lilian Gong at Gong Nash Pascoe, Inc. ("Gong Nash"), filed an appeal request appealing the Notice of Program Reimbursement ("NPR") dated April 7, 2016 for FY 2013. The appeal request contained the following six (6) issues:

1. DSH Reimbursement - Medicaid Ratio: Dual Eligible Part A Days
2. DSH Reimbursement - Medicaid Ratio: Medicare Part C Days - ***remanded***
3. DSH Reimbursement - Medicaid Ratio: Accuracy of State Data - ***withdrawn***
4. DSH Reimbursement - SSI Ratio: Medicare Part A Unpaid Days
5. DSH Reimbursement - SSI Ratio: Medicare Part C Days - ***remanded***
6. DSH Reimbursement - SSI Ratio: Accuracy of Underlying Data – ***transferred***

The Provider and Medicare Contractor filed the first page of their preliminary position papers on May 15, 2017 and September 29, 2017, respectively, consistent with the Board Rules then in effect.

On November 2, 2017, the Provider withdrew Issue 3.

On April 5, 2023, the Board remanded the Part C Days issues (Issue 2 and 5) to the Medicare Contractor as required by CMS Ruling 1739-R.

On April 28 2023, the Provider filed its complete final position paper. On May 25, 2023, the Medicare Contractor filed its complete final position paper.

On June 28, 2023, the Provider filed notice, changing its representative from Gong Nash to J.C. Ravindran at Quality Reimbursement Services ("QRS").

On July 24, 2023, QRS filed correspondence acknowledging that the instant appeal only had pending Issues 1, 4 and 6 and requested that Issue 6 (concerning the SSI Ratio: Accuracy of Underlying Data) be transferred to the optional group under Case No. 20-0106G.[1]

On July 25, 2023, QRS filed the instant EJR request. While the EJR Request does not specify which issue(s) it relates to, the only issues to which it can apply are Issues 1 and 4 since (a) QRS had already requested transfer of Issue 6 the day before; and (b) the EJR request concerns, in part, the substance of Issues 1 and 4. As discussed *infra*, the Board finds that the appeal does not contain the remaining parts of the EJR request.

On August 8, 2023, the Board reopened Case No. 20-0106G to allow transfer of Issue 6 (concerning the SSI Ratio: Accuracy of Underlying Data). On August 9, 2023, QRS transferred Issue 6 to Case No. 20-0106G entitled "QRS CY 2013 DSH SSI Percentage (3) Group." As a result, the sole remaining issues in this appeal are Issues 1 and 4 entitled "DSH Medicaid Ratio Dual Eligible Part A Days" and "DSH SSI Ratio Medicare Part A Unpaid Days" respectively. This means that the EJR request can only relate to Issues 1 and 4.

II. Statutory and Regulatory Background

A. Adjustment for Medicare DSH

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

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific

[1] *See also*, PRRB Case 16-2426, Request to Re-Open Closed Groups to Allow Transfer (July 24, 2023) (the request to reopen also acknowledges that "QRS is requesting separately, expedited judicial review for the following two issues: Issue #1 DSH - Medicaid Ratio: Dual Eligible Part A Days and Issue #4 SSI Medicare Part A Unpaid Days.").
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] 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.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

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[5] *See* 42 C.F.R. 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] (Emphasis added.)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[12]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation (FY 2005 IPPS Final Rule)

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[13] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[14]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[15] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[16] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[17]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[18] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[19] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals

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[12] 42 C.F.R. § 412.106(b)(4).
[13] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* at 27207-27208.
[18] *Id.* at 27207-08.
[19] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[20] In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[21] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[22] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[23] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[24]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[25] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[26]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[27]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage

[20] 68 Fed. Reg. at 27208.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[26] *Id.*
[27] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[28]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[29]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[30] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[31] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[32]

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[28] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[29] *Id.* at 49099 (emphasis added).
[30] *Id.*
[31] *See id.* at 49099, 49246.
[32] (Emphasis added.)

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[33]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[35] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[36] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[37] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[38] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[39] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[40] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[41] found that the Secretary's interpretation that that an individual is "entitled to

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[33] (Emphasis added.)
[34] *Id.*
[35] 317 F. Supp. 3d 168 (D.D.C. 2018).
[36] *Id.* at 172.
[37] *Id.* at 190.
[38] *Id.* at 194.
[39] *See* 2019 WL 668282.
[40] 718 F.3d 914 (2013).
[41] 657 F.3d 1 (D.C. Cir. 2011).

benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[42]

In the third case, *Empire Health Found. v. Price* ("*Empire*"), the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[43] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[44] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that: (1) without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments; and (2) interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[45] and that the regulation is procedurally invalid.[46]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[47] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[48] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[49] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hosp. & Health Ctr. v. Shalala* ("*Legacy Emanuel*")[50] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[51] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[52] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's]

[42] 718 F.3d at 920.
[43] 334 F. Supp. 3d 1134, 1141 (E.D. Wash. 2018).
[44] *Id.*
[45] *Id.* at 1162.
[46] *Id.* at 1163.
[47] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[48] *Id.* at 884.
[49] *Id.* at 884.
[50] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[51] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[52] *Id.* at 886.

contrary interpretation of that phrase is substantively invalid pursuant to APA."[53] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

The Secretary appealed the Ninth Circuit decision and the United States Supreme Court subsequently issued its decision in *Becerra v. Empire Health Foundation*[54] ("*Empire Health"*) finding that the Secretary "correctly construes the statutory language at issue."[55] The Court found that: (1) the structure of the DSH provisions supported the Secretary, summarizing that "Counting everyone who qualifies for Medicare benefits in the Medicare fraction—and no one who qualifies for those benefits in the Medicaid fraction—accords with the statute's attempt to capture, through two separate measurements, two different segments of a hospital's low-income patient population"; and (2) being "entitled" to Medicare benefits means meeting the basic statutory criteria, not actually receiving payment for a given day's treatment.[56] Nor did the Court find any credence in the argument that "entitled" was modified by the statute by adding "(for such days)". Though this parenthetical does direct the Secretary to evaluate a patient's status on a given day, it does not invite an evaluation of whether a patient *received* Part A payments, but rather whether it is qualified to receive part A payments.[57] Based on the foregoing, the Court reversed the Ninth Circuit's *Empire* decision and remanded the case for further proceedings.[58]

On remand, the Ninth Circuit is now addressing the appellant's "remaining challenge."[59] Specifically, it noted that neither the Ninth Circuit or the Supreme Court addressed the appellant's alternative argument concerning the Secretary's calculation of patient days for those patients "entitled to supplemental security income [SSI] benefits," which also factors into the Medicare fraction.[60] The argument claims that there is an inconsistency in between "entitled to Medicare" and "entitled to SSI." As discussed above, "entitled to Medicare" Part A has been deemed to mean legally entitled to benefits, regardless of whether payment was actually made, but the Secretary's policy for SSI benefits includes those patient days only when SSI benefits are paid to an individual on a given month, not merely when they are eligible for benefits.[61] Consideration of this issue is now pending before the District Court for the Eastern District of Washington.[62]

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[53] *Id.*
[54] 142 S.Ct. 2354 (2022).
[55] *Id.* at 2362.
[56] *Id.*
[57] *Id.* at 2365.
[58] *Id.* at 2368.
[59] *Empire Health Found. v. Azar*, 2022 WL 17411382, *1 (9th Cir. 2022).
[60] *Id.*
[61] *Id.*
[62] *Id.* at *2. Following the Supreme Court's remand in *Empire*, the district court initially dismissed this alternative argument for lack of subject matter jurisdiction. The Ninth Circuit reversed that decision and ordered the district

As of the date of this decision, the Secretary has not changed his position on the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule).

C. The Secretary's policy on what the phrase "entitled to supplemental security income benefits" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means for purposes of the numerator of the SSI fraction used in the DSH adjustment calculation (FY 2011 IPPS Final Rule)

As discussed above, the Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[63] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[64]

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court "to consider the argument in the first instance and to obtain supplemental briefing on the impact of the Supreme Court's ruling . . . ." *Id.*

[63] (Emphasis added.)

[64] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).

This particular issue involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[65] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[66] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[67]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[68] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[69]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[70] and may terminate,[71] suspend[72] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[73] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[74]
2. The individual fails to apply for other benefits to which the individual may be entitled;[75]
3. The individual fails to participate in drug or alcohol addiction treatment;[76]
4. The individuals is absent from the United States for more than 30 days;[77] or

[65] 42 U.S.C. § 1382.
[66] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[67] 20 C.F.R. § 416.202.
[68] 42 U.S.C. § 426.
[69] 42 U.S.C. § 426-1.
[70] 20 C.F.R. § 416.204.
[71] 20 C.F.R. §§ 416.1331-1335.
[72] 20 C.F.R. §§ 416.1320-1330.
[73] 20 C.F.R. § 1320.
[74] 20 C.F.R. § 416.207.
[75] 20 C.F.R. § 416.210.
[76] 20 C.F.R. § 416.214.
[77] 20 C.F.R. § 416.215.

5. The individual becomes a resident of a public institutions or prison.[78]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[79]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[80] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[81] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[82] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[83] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[84]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[85]

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[78] 20 C.F.R. § 416.211.
[79] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[80] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[81] *Id.*
[82] *Id.*
[83] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[84] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[85] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[86] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[87] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[88]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[89] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[90]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[91] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[92] CMS responded in detail to this comment and explained that CMS interprets

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received a forced payment from an SSA filed office; (2) "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;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id*. at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[86] CMS-1498-R at 5.

[87] *Id.*

[88] *Id.* at 5-6.

[89] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[90] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[91] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

[92] *Id.* at 50280.

SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[93] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[94] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[95]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[96] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[97] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[98]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[99]

However, neither Ruling 1498-R nor Ruling 1498-R2 are applicable to this appeal since the NPR at issue was issued after Ruling 1498-R and since the fiscal year at issue is not covered by Ruling 1498-R2. As a result of the new regulation and new data match process, CMS calculated SSI percentages for the Provider for the fiscal year at issue.[100]

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[93] *Id.* at 50280-50281.
[94] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[95] *Id.* at 50285.
[96] CMS-1498-R at 6-7, 31.
[97] *Id.* at 28, 31.
[98] 75 Fed. Reg. at 24006.
[99] CMS-1498-R2 at 2, 6.
[100] CMS published the SSI ratios for FY 2014 on or about July 5, 2016. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

III. THE PROVIDER'S APPEAL REQUEST AND ITS EJR REQUST

The EJR requests states that it pertains two separate issues identified as the "Part A Days Issue" and the "SSI Days Issue" and, for each issue, it is challenge a policy identified as the "Part A Days Policy" and "SSI Days Policy" respectively. The following chart breaks this out as follows:

	Part A Days Issue	**SSI Days Issue**
Issue that is alleged to have been included in the Provider's Appeal Request[101]	"[W]hether patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation"	"[A]lternatively, whether all of the Provider's patients entitled to supplemental security income ("SSI") should be included in the DSH calculation"
Issue for the EJR request	"Part A Days Issue" Description – "Whether patient days associated with patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation?"	"SSI Days Issue" Description – "Alternatively, if 'entitled' to Medicare Part A includes patients for whom no payment is made, whether the numerator of the Medicare fraction of the Medicare DSH percentage should include all of the Provider's patients entitled to supplemental security income ("SSI"), as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
Policy Being Challenged	"Part A Days Policy" Description – "The Provider challenges the policy of the Centers for Medicare & Medicaid Services ("CMS") to include in the DSH Medicare Fraction all patients enrolled in Part A without regard to whether a Part A payment was made."	"SSI Days Policy" Description – "Alternatively, if "entitled" means all such Part A patients, then "entitled" to SSI should not be limited to only three codes: CO1, M01 and M02 to identify persons entitled to SSI. See 75 Fed. Reg. at 50280-81 (August 16, 2010)."
Final Rule Being Challenged	FY 2005 IPPS Final Rule, 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) wherein the "Part A Days Policy" was finalized.	FY 2011 IPPS Final Rule, 75 Fed. Reg. 50042, 50280-81 (Aug. 16, 2010) wherein the "SSI Days Policy" was finalized.

[101] The quotes were taking from the EJR request as follows: first row from the EJR Request at 1 (footnote at end of second quote omitted); the second row from the EJR Request at 1-2; the third row from the EJR request at 2. For the fourth row, *see* EJR Request at 2, 9, 11.

A. Appeal Request for Issues 1 and 4

In its appeal request, the Provider describes Issue 1 (DSH Reimbursement - Medicaid Ratio: Dual Eligible Part A Days) as follows:

> **Description of the Issue**
>
> *The Provider contends* that days related to dual eligible patients who have exhausted their Medicare Part A benefits should be ***included*** *in the Medicaid Fraction* for purposes of calculating DSH Reimbursement.
>
> Dual eligible days include patient days associated with those patients who were not included in the SSI denominator by CMS' design as they were not directly billed to Medicare and did not flow through the Medicare Provider Analysis and Review ("MEDPAR") system. These days are not allowed as "Medicare eligible" by the MAC in the Medicaid numerator, hence, neither the Medicaid fraction nor the Medicare fraction captured the days associated with this indigent population.
>
> Dual eligible days were excluded from the Medicaid fraction for a variety of reasons. By way of example, some dual eligible days are associated with patients who are eligible for Medicaid but have exhausted their Medicare benefits ("Exhausted Days") or Medicare was the secondary payer ("MSP Days"). In Edgewater Medical Center (Chicago, IL.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois, PRRB Hearing Dec. No. 2000-D44 (April 7, 2000), the Board held:
>
> > The Board continues to maintain that the DSH numerator should include days of dually eligible patients whose Medicare Part A benefits were exhausted and who were eligible for reimbursement under the State's Medicaid plan. See Jersey Shore Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey, PRRB Case No. 99-D4, Medicare and Medicaid Guide (CCH) ¶80,083, October 30, 1998, vacated and remanded, HCFA Administrator, January 4, 1999, Medicare and Medicaid Guide (CCH) ¶80,153 ("Jersey").
>
> Thus, in accordance with the Board's holding in the Edgewater, the *Medicaid ratio should* ***include*** *all "Exhausted Days*".[102]

[102] Appeal Request, Tab 3, Issue 1 (Sept. 2, 2016) (bold and underline emphasis in title in original, bold and italics emphasis in body added).

The Provider describes Issue 4 ("DSH Reimbursement - SSI Ratio: Medicare Part A Unpaid Days") as follows:

> **Description of the Issue**
>
> Under current CMS methodology (as outlined in CMS Ruling 1498-R), the SSI ratios are calculated to include "the inpatient days of a person entitled to Medicare Part A in the numerator of the hospital's SSI fraction (provided that the patient was also entitled to SSI) and in that fraction's denominator, even if the inpatient stay was not covered under Part A or the patient's Part A hospital benefits were exhausted." CMS' view is that a beneficiary remains entitled to Medicare Part A even if their Part A benefits are exhausted.
>
> ***The Provider's view*** *is that once their Part A benefits are exhausted, the beneficiary is no longer "entitled" to Part A*. The plain language of the Medicare statute defines entitlement to benefits under Part A as the right to have payment made on the patient's behalf for covered services.
>
> Various U.S. courts have found that the term "entitlement" denotes a right to have payment made under Part A of Title XVIII. *Since Medicare Part A benefits have been exhausted,* ***the patients whose days are at issue*** *were clearly not entitled to have payment made on their behalf for those days, therefore, the days should be* ***excluded*** *from the SSI Fraction*.[103]

In summary:

- Issue 1 claims that dually eligible patients who have exhausted their Medicare Part A benefits (as well as Medicare Secondary Payor days) should be ***included in*** the numerator of ***the Medicaid Fraction***;
- Issue 4 claims that patients who have exhausted their Medicare Part A benefits are not "entitled" to Part A and, thus, should be ***excluded from*** the numerator and denominator of ***the Medicare Fraction***; and
- Together, both issues relate to which fraction, if any, should capture exhausted and MSP days in the DSH calculation, which turns on when a beneficiary is "entitled" to Medicare Part A benefits.

Significantly, neither Issue 1 nor Issue 4 addresses or asserts that the numerator of the SSI fraction is *underinclusive* of SSI days or that the phrase "entitled to [SSI] benefits" should be

[103] Appeal Request, Tab 3, Issue 4 (Sept. 2, 2016) (bold & underline emphasis in title in original, bold & italics emphasis in body added).

more broadly interpreted to include SSI eligible individuals. As such, neither Issue 1 nor Issue 4 addresses the "SSI Days Issue" set forth in the EJR Request.

B. Position Papers

The Provider's Final Position Paper, filed April 28, 2023, is 109 pages in length covering the 3 issues then-remaining in this appeal when that position paper was filed (the SSI Ratio: Accuracy of Underlying Data was later transferred). It also provides extensive discussion on the history of different aspects of the DSH payment, though some of the discussion not directly relates to the issues appealed in the case but rather raises new issues not included in the appeal request per the requirements at 42 C.F.R. § 405.1835(b) and Board Rules 7 and 8. Most of the position paper (pages 41 to 109) is devoted to Issue 6 entitled "SSI Ratio: Accuracy of Underlying Data" which transferred to an optional group (Case No. 20-0106G) 15 days after the instant EJR request being filed.[104] In discussing Issues 1 and 4, the position paper specifically discusses the FY 2005 and FY 2011 IPPS Final Rules, outlined above.

For Issue 1 (Medicaid Ratio: Dual Eligible Part A Days), the Provider expands on its issue statement explaining that it concerns both exhausted days and MSP days – both of which are scenarios where a party other than Medicare has made payment for an inpatient hospital stay.[105] It recounts how the FY 2005 IPPS Final Rule deleted the word "covered" from 42 C.F.R. § 412.106(b)(2)(i), resulting in both exhausted and MSP days being included in the Medicare fraction. The Provider believes, for many reasons, that these days should be excluded from the Medicare fraction but included in the Medicaid fraction.[106] It acknowledges that the *Empire* litigation resulted in a finding by the Supreme Court that the Part A Days Policy in the FY 2005 IPPS Final Rule was *substantively valid* and, as such, concedes that the substantive validity is resolved.

With respect to the procedural validity of the Part A Day Policy, the Provider acknowledges that the U.S. Court of Appeals for the Ninth Circuit held that, in *Empire*, the Part A Days Policy issued in the FY 2005 IPPS Final Rule was procedurally valid and that this portion of its *Empire* decision was not reviewed by the Supreme Court.[107] The Provider further asserts that the procedural validity issue has not been review outside the Ninth Circuit with one exception involving that the U.S. District Court for the District of Columbia which, in 2018, found it to be procedurally valid in *Stringfellow*.[108] In its Final Position Paper, the Provider argues that the regulations set forth in the FY 2005 IPPS Final Rule were improperly promulgated and should be vacated. It claims there was insufficient notice and comment and that the rule is not the product of reasoned decision making.[109]

In its final position paper, the Provider characterizes Issue 4 (SSI Ratio: Medicaid part A Unpaid Days) as alternative argument stating "[i]n the event of a holding that 'entitled' to Part A Days does not require Part A payment, the Provider in the alternative contends that 'entitled' to SSI must

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[104] As noted above, the transfer of Issue 6 occurred on August 9, 2023, 16 days after the EJR request was filed on July 24, 2023.
[105] Provider's Final Position Paper, 28 (Aug. 28, 2023) ("Provider's FPP").
[106] *Id.* at 28-29.
[107] *Id.* at 29.
[108] *Id.* at 29-30.
[109] *Id.* at 30-34.

have the identical meaning as 'entitled' to Part A." It describes the data match process laid out in the FY 2011 proposed and final rules and takes issue with the decision of CMS to only use three SSI payment status codes to identify persons "entitled to SSI." Based on the proceedings in *Empire*, the Provider argues that CMS is interpreting "entitled" to SSI differently than "entitled" to Part A, despite both terms being used in the same regulation at 42 C.F.R. § 412.106(b)(2)(i)(B). It concludes that all patients who are enrolled in SSI should be included when counting patients "entitled" to SSI.[110] However, the final position paper does not discuss how this ties back to its original description of Issue 4 in its appeal request which simply sought exclusion of no-pay Part A days from the SSI fraction:

> ***The Provider's view*** is that once their Part A benefits are exhausted, the beneficiary is no longer "entitled" to Part A. . . .
>
> Since Medicare Part A benefits have been exhausted, the patients whose days are at issue were clearly not entitled to have payment made on their behalf for those days, *therefore, the days should be* ***excluded*** *from the SSI fraction*.[111]

Finally, the Provider raises this ***same*** SSI "entitled" issue in the context of Issue 6 and devotes many pages to it (in contrast to the argument on Issue 4 which is 7 pages long). Significantly, the 69 pages of argument on Issue 6 match the topic areas appear to line up with the issue statement for the optional group (Case No. 20-0106G) to which the Provider transferred Issue 6.[112] Significantly, the EJR request appears to recognize the "transfer[] the SSI Days Issue to a pending Group" when discussing the Board's jurisdiction over the Provider's appeal:

> As evidenced by the Model Form A (Exhibit 2), the Provider *timely filed their appeal of* ***the SSI Days Policy*** by (a) filing individual appeals within 180 days of the notice of program reimbursement ("NPR") (or timely adding the SSI Days Issue to a timely filed appeal) ***and*** *then transferring* ***the SSI Days Issue*** *to a pending Group* or (b) directly appealing the SSI Days Issue to a pending Group within 180 days of the NPR.[113]

Thus, the EJR request ***concedes*** the SSI Days Issue is not currently pending in the instant case.

C. EJR Request

The Provider filed an EJR Request which alleges that it *appealed*:

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[110] *Id.* at 38-41.
[111] (Emphasis added.)
[112] The Board has not fully reviewed Case No. 20-0106G to confirm whether the issue statement for Case No. 20-0106G and final position paper in this case, as it relates to Issue 6, fully line up. However, it is clear that both discuss the SSI Days Issue. Similarly, the reopening to permit the transfer did ***not*** review Issue 6 to confirm that the jurisdictional and claim filing requirements in 42 C.F.R. §§ 405.1837(a)-(b) and 405.1840 have been met.
[113] EJR Request at 4 (emphasis added).

> [W]hether patients entitled to Medicare Part A for whom no Medicare Part A payment is made and who are eligible to Title XIX should be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction of the [DSH] calculation ***or***, *alternatively*, whether all of the Provider's patients entitled to [SSI] should be included in the DSH calculation.[114]

The Provider does not specify which issues from the original appeal are encompassed in this EJR Request, but it appears to be seeking EJR over the substance of issues 1 and 4.[115] The EJR Request confusingly argues that these two issues are really two components of a single issue, but that "[i]f, however, the Board finds that these two issues are distinct the Provider will request that the Board bifurcate into two separate groups." The Board notes that this is an individual appeal. This is likely due to the recycling of briefs.[116]

The issue arises again, and more importantly, when discussing the *Empire* decision, where the EJR Request ***incorrectly*** asserts that "the Provider is ***not*** located in the jurisdiction or bound by the decisions of [the Ninth Circuit in *Empire* or the D.C. District Court in *Stringfellow*]."[117] The Provider is located in California, which is in the Ninth Circuit and, as such, is bound by the Ninth Circuit's holding in *Empire* that the Part A Days Policy in the FY 2005 IPPS Final Rule is procedurally valid. Additionally, despite the contention that the entirety of its EJR request covers just a "single" issue, the Provider outlines two very specific challenges to "The Part A Days Issue" and the "SSI Days Issue" which Board Rule 8 specifically identifies as two separate issues.

The EJR Request, in large part, repeats the arguments made in the Final Position Paper filed just a few months prior. For what it describes as the "Part A Days Issue," the Provider outlines the history of the Part A Day Policy finalized in the FY 2005 IPPS Rule, acknowledges and concedes that *Empire* found the Part A Days Policy was substantively valid, but is now arguing it is *procedurally* invalid.[118]

For what it describes as the "SSI Days Issue," the Provider outlines the history of the FY 2011 IPPS Rule and argues that the three codes used for CMS' data matching process set forth therein do not capture all days for patients who are "entitled to SSI." The argument is grounded in the claim that the Supreme Court's holding in *Empire* as to the meaning of "entitled" in the phrase "entitled to benefits under [Medicare] part A" should be identical to the meaning that same term in the phrase "entitled to [SSI] benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).[119]

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[114] Provider's Request for Expedited Judicial Review, 1 (July 25, 2023) ("EJR Request") (emphasis added).
[115] *See* PRRB Case 16-2426, Request to Re-Open Closed Groups to Allow Transfer (July 24, 2023) ("QRS is requesting separately, expedited judicial review for the following two issues: Issue #1 DSH - Medicaid Ratio: Dual Eligible Part A Days and Issue #4 SSI Medicare Part A Unpaid Days.").
[116] EJR Request at 4.
[117] *Id.* at 7.
[118] *Id.* at 5-11.
[119] *Id.* at 11-18.

The Provider concludes that the Board lacks authority to decide its challenge to the Part A Days Policy and the SSI Days Policy and, therefore, the Board should grant EJR.

IV. DECISION OF THE BOARD

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

The sole remaining issues in this appeal are Issues 1 and 4. As such, the EJR request must relate to these issues. Indeed, on July 24, 2023, the day before filing the EJR request, QRS file correspondence acknowledging that the instant appeal only had pending Issues 1, 4 and 6 and requested that Issue 6 (concerning the SSI Ratio: Accuracy of Underlying Data) be transferred to the optional group under Case No. 20-0106G. Shortly thereafter, on August 8, 2023, the Board reopened the optional group to allow the transfer which occurred the following day.

While the EJR Request should but does not specify to which issue(s) from the appeal request it relates, the only issues to which it can apply or relate are Issues 1 and 4 since: (a) QRS had already requested transfer of Issue 6 day before; and (b) the EJR request concerns, in part, the substance of Issues 1 and 4. Indeed, to the extent the Provider were to assert that the EJR request does not relate to these 2 issues, then the Provider had an obligation to explain to what issues the EJR request relates because this is a necessary part of an EJR request at Board Rule 42. Board Rule 42.3 specifies that the EJR request must "[i]dentif[y] the issue for which EJR is requested" and "[d]emonstrate[] that the Board has jurisdiction."[120]

As discussed *infra*, the Board reviewed Issues 1 and 4 and finds that they only address the Part A Days Issue and do ***not*** address the SSI Days Issue.

A. Background on Jurisdiction for Appeals of Cost Report Periods Beginning After December 31, 2008 and Before January 1, 2016

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost,"

[120] Board Rule 42.3 makes clear that an EJR request must explain how the Board has jurisdiction over the issue for which EJR is being request. In order to have jurisdiction over an issue, it must have been properly appealed and set forth in the appeal request in the first instance. In this regard, 42 C.F.R. § 405.1835(b) describes the claim filing requirements for each issue being appealed. However, the appeal request does not tie the SSI Days Issue back to the appeal request and does not describe how that issue was part of the original appeal request and how the SSI Days Issue is still currently pending in the individual appeal.

pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[121] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[122]

On August 21, 2008, revisions to the Board's governing regulations became effective.[123] One of the revised regulations was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[124] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[125]

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

B. Board Analysis on the Scope of the EJR Request as it Relates to the Appealed Issues Remaining in this Case

As discussed *supra*, the two issues from the Provider's original appeal request (filed September 2, 2016) for which it is now requesting EJR can be summarized as follows:

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[121] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[122] *Bethesda at 1258-59.*
[123] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[124] 201 F. Supp. 3d 131 (D.D.C. 2016).
[125] *Id.* at 142.

- Issue 1 claims that dually eligible patients who have exhausted their Medicare Part A benefits (as well as Medicare Secondary Payor days) should be ***included in*** the numerator of ***the Medicaid Fraction***, and

- Issue 4 claims that patients who have exhausted their Medicare Part A benefits are not "entitled" to Part A and, thus, "should be ***excluded from*** [the numerator and denominator of} ***the SSI Fraction***,"[126] and

- For both of these issues, the Provider identifies the days at issue as involving "dual eligible patients who have exhausted their Medicare Part A benefits"[127] and this is based on "[t]he Provider's view . . . that once their Part A benefits are exhausted, the beneficiary is no longer 'entitled' to Part A."[128]

- Together, both issues relate to which fraction, if any, should capture exhausted and MSP days in the DSH calculation, which turns on when a beneficiary is "entitled" to ***Medicare Part A benefits***.

Both of these issues relate to the interpretation of entitled to Medicare Part A benefits. Specifically, Issue 4 focuses on interpreting the phrase "entitled to benefits under [Medicare] part A" as used in § 1395ww(d)(5)(F)(vi)(I) for the SSI fraction (Issue 4); and Issue 1 focuses on interpreting the phrase "*no*t entitled to benefits under [Medicare] part A"[129] as used in § 1395ww(d)(5)(F)(vi)(I) for the Medicaid fraction SSI fraction (Issue 1).

Significantly, neither issue discusses the SSI Days Issue, *i.e*., what the phrase "entitled *to* ***supplemental security income*** *[i.e., SSI] benefits*" in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) means and contending that it is interpreted to narrowly such that the numerator of the SSI fraction is undercounted.[130] The phrase "entitled to [SSI] benefits" pertains to the numerator of the SSI fraction. More specifically, Issue 1 only relates to the Medicaid fraction and, as such, cannot encompass the SSI Days Issue. Similarly, while Issue 4 relates to the SSI fraction, the Appeal Request makes clear that Issue 4 only relates to dual eligible patients who have exhausted their Medicare Part A benefits" and requests that this class of days be "*excluded* from the SSI fraction."[131] Issue 4 cannot relate to the SSI Days Issue since it does contend that the numerator of the SSI fraction is undercounted and/or that the phrase "entitled to [SSI] benefits" is interpreted too narrowly.

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[126] Appeal Request at Tab 3, Issue 4 (emphasis added).
[127] Appeal Request at Tab 3, Issue 1.
[128] *Id.* at Tab 3, Issue 4. *See also id.* (stating: "Various U.S. courts have found that the term 'entitlement' denotes a right to have payment made under Part A of Title XVIII. *Since Medicare Part A benefits have been exhausted*, the patients whose days are at issue were clearly not entitled to have payment made on their behalf for those days, therefore, the days should be excluded from the SSI Fraction." (emphasis added)).
[129] (Emphasis added.)
[130] They simply do not discuss, involve, or implicate in any way the interpretation of "entitled to SSI" and the FY 2011 IPPS Final Rule.
[131] (Emphasis added.)

Based on the above discussion, it is clear that the issue statements for Issues 1 and 4 did not include the SSI Days Issue and did not meet the following claim filing requirements in 42 C.F.R. § 405.1835(b) (2014):

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the contractor's or Secretary's determination under appeal.
>
> (2) **An explanation (for <u>each</u> specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) **Why the provider believes Medicare payment is incorrect for <u>each</u> disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) **How and why the provider believes Medicare payment must be determined <u>differently</u> for <u>each</u> disputed item**.
>
> (iii) If the provider self-disallows a specific item, **a description of the nature and amount of <u>each</u> self-disallowed item** and the reimbursement or payment sought for the item.
>
> (3) A copy of the contractor or Secretary determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[132]

[132] (Bold and underline emphasis added, italics in original.)

Here, neither Issue 1 nor Issue 4 relate to the SSI Days Issue since the issue statement for these issues in the appeal request fails to explain "why Medicare payment is incorrect" in connection with this issue (*i.e*., because "entitled to [SSI] benefits" is interpreted too narrowly) or similarly "how and why the provider believes Medicare payment must be determined differently" for this issue. Further, as the SSI Days Issue is a self-disallowed item,[133] it further fails to give "a description of the nature and amount" involved with the SSI Days Issue as there is no separate amount in controversy calculation for the SSI Days Issue (which again does not involve excluding days from the SSI fraction but rather increasing the numerator of the SSI fraction).

Indeed, the Board finds that, to the extent the SSI Days Issue was ever part of this appeal, it was transferred ***prior to*** the EJR request being filed.[134] As discussed *supra*, in the final position paper, the Provider raises this ***same*** SSI "entitled" issue in the context of Issue 6 and the Provider transferred Issue 6 the optional group (Case No. 20-0106G). Significantly, the 67 pages of argument on Issue 6 in that position paper appear to line up with the issue statement for the optional group (Case No. 20-0106G) to which the Provider transferred Issue 6.[135] Significantly, the EJR request appears to recognize the impending "transferring [of] the SSI Days Issue to a pending Group" when discussing the Board's jurisdiction over the Provider's appeal:

> As evidenced by the Model Form A (Exhibit 2), the Provider *timely filed their appeal of* ***the SSI Days Policy*** by (a) filing individual appeals within 180 days of the notice of program reimbursement ("NPR") (or timely adding the SSI Days Issue to a timely filed appeal) ***and*** *then transferring* ***the SSI Days Issue*** *to a pending Group* or (b) directly appealing the SSI Days Issue to a pending Group within 180 days of the NPR.[136]

As a provider cannot pursue the same issue for the same year in more than one appeal (*see* Board Rule 4.6), it is clear that the EJR request itself ***concedes*** the SSI Days Issue is not currently pending in the instant case. Accordingly, the Board finds the SSI Days issue is not currently part of the appeal and denies the EJR as it relates to the SSI Days Issue and the SSI Days Policy.[137]

In summary, the Board reviewed the appeal request to confirm whether the Board has jurisdiction over the Part A Days Issue and finds that it does. The sole remaining issues in this appeal are Issues 1 and 4 and, as set forth below, the Board has determined that these issue solely relate to the meaning of "entitled to Part A" is governed by CMS Ruling CMS-1727-R since the

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[133] In using the term "self-disallowed," the Board is referring to the fact that the Provider must accept the SSI rate published by CMS and has no ability to otherwise alter it or claim something different when filing its cost report.
[134] In making this finding, the Board is not ruling that Issue 6 encompasses the SSI days issue and will review that as part of the jurisdictional review of the optional group.
[135] The Board has not fully reviewed Case No. 20-0106G to confirm whether the issue statement in Case No. 20-0106G and final position paper in this case as it relates to Issue 6 fully line up. However, it is clear that both discuss the SSI Days Issue. Similarly, the reopening to permit the transfer did ***not*** review Issue 6 to confirm that the jurisdictional and claim filing requirements in 42 C.F.R. §§ 405.1837(a)-(b) and 405.1840 have been met.
[136] EJR Request at 4 (emphasis added).
[137] *See supra* note 135 and accompanying text.

Providers are challenging the Secretary's interpretation of this phrase as used in the Part A Days Policy finalized/adopted in the FY 2005 IPPS Final Rule and that Board review of this issue is not otherwise precluded by statute or regulation. In addition, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal. The appeal was timely filed and no jurisdictional impediments have been identified for the Provider. Based on the above, the Board finds that it has jurisdiction for the above-captioned individual appeal as it relates to the Part A Days Issue.

C. Board analysis of the EJR Request

The Provider's Final Position Paper and EJR Request were both filed in 2023 ***after*** the Supreme Court's decision in *Empire*. As a result, they both dedicate a significant amount of discussion to the meaning of "entitled to benefits under [Medicare] part A" as it relates to the interpretation of the Part A Days Policy finalized/adopted in the FY 2005 IPPS Final Rule. Further, as outlined, *supra*, the Part A Days Issue stated in the EJR Request involves the Part A Days Policy finalized in the FY 2005 IPPS Final Rule, which was the subject of extensive litigation. The Supreme Court has *definitively* concluded in *Empire* that this rule is substantively valid. Indeed, in both its final position paper and EJR request, the Provider acknowledges that the Supreme Court in *Empire* made this finding and, as such, ***concedes*** that the Part A Days Policy is substantively valid. Accordingly, what is left in dispute is whether the finalization/adoption of the Part A Days Policy in the FY 2005 IPPS Final Rule was *procedurally* valid.

With respect to the procedural validity issue, the Provider acknowledges that, while the Supreme Court did not consider in *Empire* any challenge to the *procedural* validity of the Part A Days Policy as finalized/adopted in the FY 2005 IPPS Final Rule, the Ninth Circuit did so and it determined that the adoption/finalization of the Policy was procedurally valid.[138] While the EJR Request ***incorrectly*** notes that "the Provider is ***not*** located in the jurisdiction or bound by the decisions of [the Ninth Circuit in *Empire* or the D.C. District Court in *Stringfellow*,]"[139] the Provider is located in the Ninth Circuit since it is located in California and, as such, is bound by the Ninth Circuit.[140] However, none of these facts or discrepancies prevent the Provider from

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[138] 958 F.3d. at 884.

[139] EJR Request at 7 (emphasis added).

[140] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor Room Days Grps. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). Further, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit if the D.C. Circuit has addressed the issue (which may be in additive to the Circuit in which it is located if it has also addressed the issue). *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007). For example, prior to the Supreme Court's decision in *Your Home Visiting Nurse Servs. v. Shalala*, 119 S. Ct. 930 (1999), CMS (then HCFA) issued guidance creating an exception for providers located in the Ninth Circuit Court of Appeals based on the Ninth Circuit's decision in *Your Home* which was later reviewed and overturned by the Supreme Court. *See* Provider Reimbursement Manual, CMS Pub 15-1, Ch. 29, Transmittal No. 410 (Aug. 1, 1999) (revising § 2924.4 to "delete[] the exception for providers located within the Ninth Circuit Court of Appeals when providing that a decision denying jurisdiction of an appeal of an intermediary's refusal to

pursuing an EJR request on the procedural validity of the finalization/adoption of the Part A Days Policy in the FY 2005 IPPS Final Rule.

To the extent the *procedural* validity of the Secretary's finalization/adoption of the Part A Days Policy (and related regulation revisions) in the FY 2005 IPPS Final Rule is challenged, it would appear that a successful challenge would only result in reinstatement of the prior policy which was simply to ***not*** count no-pay Part A days in either the Medicare or Medicaid fractions and, as such, would have no impact on the Medicaid fraction. The Board views the challenge to the Part A Days Policy to include no pay Part A days in the Medicare fraction (Issue 4) as a *separate issue* from the inclusion of the subset of those days in the Medicaid fraction (Issue 1). In support of this position, the Board points to the Ninth Circuit's decision in *Empire* where they overturned the Part A Days Policy but simply reverted to the prior policy that resulted in no-pay Part A days being counted in neither fraction.[141] 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.[142]

42 C.F.R. § 405.1867 specifies that "[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* . . . ."[143] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) challenging the *procedural* validity of the finalization/adoption of the Part A Days Policy in the FY 2005 IPPS Final Rule and related revisions made to § 412.106(b)(2)(i) therein, so as to exclude no-pay Part A days from the SSI fraction; and (2) seeks the inclusion of the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction.

Based on the foregoing, the Board finds that the Provider is seeking EJR over Issues 1 and 4 in its appeal[144] and that these two issues *solely* concern the *procedural* validity of finalization/adoption of the Part A Days Policy (and related revisions to the regulations) in the FY 2005 IPPS Final

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reopen a cost report is not subject to judicial review, pursuant to *Your Home Visiting Nurse Services, Inc. v. Shalala*, 119 S.Ct. 930 (1999).").

[141] *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).

[142] 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.

[143] (Emphasis added.)

[144] *See* PRRB Case 16-2426, Request to Re-Open Closed Groups to Allow Transfer (July 24, 2023) (the reopening request acknowledges that "QRS is requesting separately, expedited judicial review for the following two issues: Issue #1 DSH - Medicaid Ratio: Dual Eligible Part A Days and Issue #4 SSI Medicare Part A Unpaid Days.").

Rule. Based on the above, the Board finds that EJR is appropriate for the Part A Days Issue and calendar year under appeal in this case.

* * * * *

In summary, the Board finds that:

1) It has jurisdiction over the Part A Days Issue for the subject year and that the Provider in Case No. 16-2425 is entitled to a hearing before the Board; however, it does not have jurisdiction over the SSI Days Issue since that issue is not pending in this case and, as such, denies the EJR request as it relates to the SSI Days Issue.[145]

2) Based upon the Provider's assertions regarding the Part A Days Policy (as finalized/adopted in the FY 2005 IPPS Rule) which was codified in 42 C.F.R. § 412.106(b)(2)(i) by the FY 2005 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal questions of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule in connection with the Part A Days Policy) is ***procedurally*** valid and, if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction.

Accordingly, the Board finds that the questions of the ***procedural*** validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule in connection with the Part A Days Policy) ***and***, if successful, what policy should then apply, properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review.

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

[145] As discussed *supra,* the Board finds that: (1) the interpretation of, validity of, and/or policies set forth in the FY 2011 IPPS Final Rule is not part of this appeal and denies its EJR Request for that issue; (2) to the extent it could have been part of the appeal, it was part of Issue 6 which was transferred to Case No. No. 20-0106G 15 days after the EJR request filing; and (3) the EJR request specifically asserts that the SSI Days Issue was being transferred.

Board Members Participating:

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

For the Board:

8/24/2023

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Venus Marin Bautista
Director of Strategic Planning and Reimbursement
Huntington Memorial Hospital
100 W. California Blvd.
Pasadena, CA 91105

RE: ***Request for Reconsideration***
Huntington Memorial Hospital, Prov. No. 05-0438, FYE 12/31/2009
Case No. 15-2480

Dear Ms. Bautista,

The Provider Reimbursement Review Board ("Board") has reviewed the letter requesting reconsideration ("Request for Reconsideration") submitted by Huntington Memorial Hospital ("Provider") on July 21, 2023. The decision of the Board is set forth below.

Pertinent Facts

On April 27, 2015, Huntington Memorial Hospital ("the Provider") filed an Individual Appeal Request from a Notice of Program Reimbursement ("NPR") dated October 22, 2014, for fiscal year ending December 31, 2009. The Provider was appealing, among other issues, Medicare Bad Debt, Indirect Medical Education, and Graduate Medical Education.

On February 13, 2023, the Board issued a Notice of Hearing and Critical Due Dates, which set a due date of July 7, 2023, for the filing of Final Position Paper ("FPP") from the Provider. The Notice of Hearing also specifically informed the Provider that "[i]f the Provider misses its due date [i.*e*, the July 7, 2023 deadline], the Board will dismiss the cases." However, the Provider failed to comply with the deadline. Accordingly, On July 10, 2023, consistent with the above warning in the Notice of Hearing, the Board dismissed and closed the Provider's case.

On July 21, 2023, the Board received a Reconsideration Request from the Provider. Board Rule 47 governs reinstatements and states in pertinent part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s) (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting

> out the reasons for reinstatement (*see* Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. . . .
>
> ****
>
> **47.3 Dismissals for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.

Notwithstanding the above rules governing reinstatement, the Provider's Request for Reinstatement simply states that the Provider has been working with the Medicare Contractor to administratively resolve the remaining issues. In its Request, the Provider failed to comply with Board Rule 47.3 as it did not include the missing document/filing (*i.e.*, the Provider's final position paper), but instead stated they "do[] not intend to file the Final Position paper or go to hearing." Additionally, the Provider requested both reinstatement and additional time to complete the administrative resolution process. As such, the Provider is at fault for its noncompliance with the requirement in Board Rule 47.3 to include a copy of the FPP with its request for reinstatement.

Statutory and Regulatory Background

Pursuant to Board Rule 27.1, filing of final position papers remains mandatory for appeals filed prior to August 29, 2018. Rule 19.2 specifies that:

> [T]he final position paper remains a required filing, and failure to timely file the final position papers may result in dismissal of the case. ***Exception:*** If, before the final position paper deadline, a provider files a withdrawal request, or the parties file a fully executed Administrative Resolution withdrawing the case, and the Board has not yet officially sent notice acknowledging closure of the case, the parties are not expected to file final position papers as the withdrawal is self-effectuating (see Rule 46).

In addition, under 42 C.F.R. § 405.1885(a)(1), the Board may reopen its decision with respect to specific findings on matters at issue in the decision. A request from a provider to reopen a Board

decision must be made within three (3) years of the decision.[1] Jurisdiction for reopening a Board decision rests exclusively with the Board.[2]

Similarly, the Board's rules allow for reinstatement of a case upon a written motion by the provider made within three (3) years of date of the Board's decision to dismiss the case. The request must set out the reasons for reinstatement, and Board Rule 47.1 (as quoted above) provides that the Board will not reinstate a case if the provider was *at fault*. As explained in Board Rule 47.3 (as quoted above), the Board may reinstate a case dismissed for failing to comply with Board Procedures *if the provider demonstrates* ***good cause***. However, "[g]enerally, administrative oversight, [or] settlement negotiations . . . will ***not*** be considered good cause to reinstate."[3] Finally, Board Rule 47.3 explains that, if the dismissal was for failure to make a filing (*e.g.*, a final position paper), "then the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion."[4]

Board's Decision

Here, the Provider has filed the Request for Reconsideration. However, it is fatally flawed because: (1) it provides no explanation that could constitute "good cause" for failing to comply with Board procedures since neither administrative error nor administrative resolution negotiations/discussions constitute good cause; and (2) the filing does not the missing filing, namely, the final position paper because, as Board Rule 47.3 explains, the Board will not even consider this request for reconsideration without that position paper. Indeed, the request simply asserts that the Provider has been working with the MAC to administratively resolve the remaining issues and a need for reinstatement to complete this resolution process. As previously noted, *neither* administrative oversight *nor* settlement/administrative resolution discussions/finalization constitute good cause for reinstatement. Accordingly, the Board hereby denies Provider's Request for Reinstatement and Case No.15-2480 remains 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.

Board Members Participating:

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

For the Board:

8/24/2023

X Clayton J. Nix

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

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

[1] 42 C.F.R. § 405.1885(b)(2).
[2] 42 C.F.R. § 405.1885(c).
[3] (Emphasis added.)
[4] (Emphasis in original).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Jeffrey Perlman
Northwell Health
972 Brush Hollow Rd, 5th Fl. Fin
Westbury, NY 11590

RE: ***Dismissal for Untimely Filing***
Phelps Memorial Hospital Association (Prov. 33-0261)
FYE 12/31/2012
Case No. 16-0032

Dear Mr. Perlman:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice.

The Provider filed an appeal in the above referenced case on October 9, 2015. On May 25, 2016, the Provider timely filed its preliminary position paper. On April 16, 2020, a Notice of Hearing was issued, setting a hearing date for December 8, 2020. Prior to the hearing, on October 13, 2020, the Provider confirmed that all Board set deadlines were on hold in accordance with Alert 19 due to Covid. The hearing date for this case was rescheduled five more times.

On November 7, 2022, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. Further the Alert specified with respect to suspended but unmet deadlines:

> For those previously suspended deadlines (original or revised) which have not been met and which have not been reissued with deadlines specifically *exempted* from Alert 19, Board Order No. 3 specifies that the Board will issue revised Notices of Hearing or Notices of Critical Due Dates on a rolling basis over the next 6 months, establishing new deadlines consistent with current Board

> Rules. If you have questions regarding your Notice of Hearing, please submit them in correspondence through OH CDMS on your specific case or contact the Board Advisor assigned to your case. If you have questions regarding any other deadline or Notice, please submit them in correspondence through OH CDMS on your specific case.[1]

On April 19, 2023, consistent with Alert 23 and Board Order No. 3, the Board issued a "Notice of Hearing and Critical Due Dates - Corrected" notification setting the Provider's final position paper due date for July 7, 2023 and the Medicare Contractor's final position paper due date for August 6, 2023.

Upon expiration of the Provider's final position paper deadline, the record was reviewed and it was noted that the Provider's earlier preliminary position paper submission (from May 2016) included a cover letter requesting the Board to consider the preliminary position paper submission to "be considered its final position paper unless this document is superseded by a subsequent filing."

However, on August 29, 2018, after the Provider's 2016 preliminary position paper filing, the Board issued updated Rules in which it advised that, because full copies of the preliminary position paper were now required, the filing of final position papers was now "optional" for cases filed AFTER the effective date of the rule. The Rules advised, however, that final position papers were still MANDATORY for all appeals that were FILED PRIOR to that date, as is the situation for this case. On November 1, 2021, the Board issued another revision of the Rules, in which it made electronic filing mandatory and reiterated that the filing of final position papers for appeals filed prior to August 29, 2018 was mandatory.

Due to the multiple postponements and reschedules over the last few years for the subject case, the Board found it necessary for the Provider to confirm whether it was still the Provider's intent to use the preliminary position paper filing from 2016 as the final position paper submission in this case. Therefore, in a notification issued on August 17, 2023, the Board afforded the Provider ten (10) days (until August 28, 2023), to upload an updated final position paper. The Board advised that failure of the Provider to meet the deadline as specified would result in dismissal of the appeal.

Pursuant to 42 C.F.R. § 405.1868:

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

[1] (Underline emphasis added; italics in original.) *See also* Board Order 3 (available at: https://www.cms.gov/regulations-and-guidance/review-boards/prrbreview/prrb-instructions (last visited on Aug. 22, 2023).

> ***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.[2]

Northwell Health has failed to *properly* file a final position paper by the original July 7, 2023 deadline set in the April 19, 2023 "Notice of Hearing and Critical Due Dates - Corrected." Notwithstanding, based on the statement in the preliminary position paper submitted more than seven (7) years ago, and after two revisions of the Rules, the Board provided Northwell Health an opportunity to confirm whether it was the Provider's intent for the Board to consider the preliminary position paper as the final position paper submission by Monday, August 28, 2023. However, Northwell Health **failed** to respond within the prescribed 10-day period. As a result, it is clear that Northwell Health has failed to *properly* file its final position paper, notwithstanding the 10-day period prescribed by the Board to confirm its intent and has abandoned its appeal. Therefore, the Board hereby dismisses the appeal pursuant to its authority under 42 C.F.R. § 405.1868. 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:
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For the Board:

8/29/2023

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Danelle Decker, National Government Services (J-K)

[2] Emphasis added.